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ABSTRACT

This investigation consisted of two studies. In Experiment I, three methods of dealing with the identified emotionally disturbed child were compared, simultaneously testing the hypothesis that community personnel can be taught to work effectively with these children. Under the three treatments, the identified child was either: (1) removed from his classroom and bussed to a special site, (2) retained in the regular classroom but taken into a special room each day to spend 20-30 minutes with a trained therapist, and (3) retained in the classroom, but with the constant support of a paraprofessional aide. In Treatment 1, these referrals had been made without consulting the research staff. For Treatment 2 and Treatment 3, stratified random assignment was made to either treatment from a large number of children identified and observed by the psychologist and the therapists. There were a total of 68 children in the combined treatment and control groups. Experiment II compared the preschool population of two clinic schools using a similar psychodynamic approach. One aspect of the investigation was designed to determine whether there were any basic differences in the type of emotional problems which characterized children from different socioeconomic backgrounds. In Experiment I, the success attained showed that community personnel can help slightly disturbed children. Although the second Experiment was never fully implemented, there seems to be sufficient basic to conclude that the problem behaviors of young children are very similar, regardless of backgrounds. (Author/CK)

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THERAPEUTIC INTERVENTIONS WITH EMOTIONALLY-DISTURBED PRESCHOOL CHILDREN[1]

by

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University of California, Los Angeles

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days; on the fifth day they met at the Center office for lectures, group discussions and other training activities. As the program progressed, visits to other types of therapy situations were set up and several trips to organizations working with handicapped children were made. The staff psychologist of the Delegate Agency met with the group once a month and there were several meetings of the Center Director with the Delegate Agency personnel. The social worker refused to permit any of the research staff to visit the home or obtain data from the parents. Although she did agree to obtain the needed data herself, only a very few protocols were returned. However, when a child was absent, the aide attempted to obtain permission to visit the home. If this was granted a great deal of useful information was obtained and the relationship with both the child and parent was strengthened.

While there were many more untestable children in the disturbed group, in general the behavior of the identified children was not always clearly different from those considered normal. In most of the videotapes it is difficult to determine why the child was referred for treatment. These videotapes provide excellent training films, but in most cases the aide or the teacher hovered over the disturbed child and discouraged any acting-out behavior. However, over the treatment period many perceptible changes were observed. Two of the six children in Treatment 2 were able to discontinue coming to the therapy sessions and two of the five children in Treatment 3 were phased out and new children taken on. Because of the structure of Treatment 1, this type of transition was impossible. Aside from the difficulty of finding space and facilities, and the stigma attached to being sent away from the regular class to a "special" school, this tendency to keep the identified children locked into the therapy setting for an entire year is a serious drawback of this type of approach.

Important gains were demonstrated with all three treatments. Unfortunately, because of the small number of cases and the diversity of conditions, no between-treatment differences were obtained and it was impossible to tease out more precisely those features which contributed most to the successes which were achieved. The most important statistically significant finding was that whereas on the screening instrument there were significant pretest differences between the disturbed and normal groups, on the posttest these two groups were no longer reliably different on this measure. However, the disturbed children were still significantly below the performance of their normal peers on their verbal and achievement scores (PPVT and Caldwell). Evidently these children had not yet had sufficient time to overcome the deficits associated with their impaired ability to function due to emotional problems.

The anecdotal records, while admittedly subjective and untestable, were very rewarding. Finally, the success achieved by the briefly-trained paraprofessionals from the local community showed that such personnel can, by working on a one-to-one basis, help slightly disturbed children who might become serious problems if this attention is not available.

Therapeutic Interventions with Emotionally-Disturbed Preschool Children

Carolyn Stern, Susan Nummedal, and Sadelle Brussell

ABSTRACT

While there are many unanswered questions as to the overall effectiveness of compensatory preschool, there is no doubt that there are many children who, because of emotional problems, are unable to benefit from even the best of programs. Often these children are simply dropped from the class roster; in a few cases they may be referred to special clinics or agencies, if they exist in any reasonable proximity to the source of need, with the hope that someone else will take care of the problem. In a most serious sense this is a penny-wise and pound-foolish expedient. Unlike the mentally-retarded child, for whom the prognosis is often extremely pessimistic, the young disturbed child may be able to come to grips with his problems after a relatively short period of attention.

The present investigation actually consisted of two separate studies. In Experiment I three methods of dealing with the identified emotionally-disturbed child were compared, simultaneously testing the hypothesis that community personnel can be taught to work effectively with these children. Under the three treatments, the identified child was either 1) removed from his classroom and bussed to a special site housing two classes of seven children each, with a Head Teacher and Assistant Teacher trained to work with disturbed children; 2) retained in the regular classroom but taken into a special room each day to spend 20-30 minutes with a trained therapist; or 3) retained in the classroom but with the constant support of a paraprofessional aide who served as a "special friend" and was with the individual child for approximately four hours a day, two days a week, over a six-month period.

All the children in this study were identified as in need of special help by the Head Start teacher, who notified the agency psychologist. In Treatment 1, these referrals had been made without consulting the research staff, and no controls were used. For Treatment 2, a large number of children were identified and observed both by the psychologist and the therapists. Each child was then rated on a modifield version of the Kohn Behavior Checklist and Competence Scale by the teacher and the observer. Stratified random assignment was made to either Treatment 2, Treatment 3, or a disturbed control group. In addition to the latter group, two normal controls were randomly selected in each classroom where there were disturbed children. There were a total of 68 children in the combined treatment and control groups.

The three paraprofessional aides were given six weeks of intensive training in a modified behavior therapy technique. During this period, they were also trained to use the behavior checklists and made ratings of the referred children as well as wrote up anecdotal reports. When the work with the children began, the aides were in the field only four

Experiment II compared the preschool population of two clinic schools using a similar psychodynamic approach. However, one was a hospital-based unit in a middle-class white setting, the other a community mental health center in a Black ghetto area. The intention of this aspect of the investigation was to determine whether there were any basic differences in the type of emotional problems which characterized children from different socioeconomic and ethnic backgrounds. Because of the many difficulties faced by the second group, which was just getting under way, it was impossible to carry out any of the necessary pretesting, and a number of the critical measures were unobtainable. However, the posttest with the Kohn instrument revealed no differences between the two clinic settings except on Factor 1 of the Competence Scale, where the Black children were rated as being more compliant and withdrawn and the White group more acting-out and aggressive. However, this finding may very well reflect differences in the basis of selection and referral, rather than actual differences in the characteristic types of problems.

Although the second study was never fully implemented, there seems to be sufficient basis to conclude that the problem behaviors of young children, whether their genesis is related to a history of discrimination and deprivation or middle-class neuroticism, are very similar and should be susceptible to similar types of therapeutic interventions.

Therapeutic Interventions with Emotionally-Disturbed Preschool Children

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Problem

While there are many unanswered questions as to the overall effectiveness of compensatory preschool programs, there is no doubt that there are many children who are unable to benefit from the most enriched environment, and that a very sizable number of the most needy children "drop out" of their first year of schooling. At present there are few programs which provide a systematic method of working with children who are unable to cope in the classroom. Often the child's attendance is subtly discouraged by repeatedly sending the child home for various problem behaviors, or the parents are told outright not to bring the child to class. In a few cases, if agencies have access to a psychologist or mental health consultant, the child may be referred to a psychiatric clinic. Unfortunately, such special services are usually not located close to the area in which the child resides; if one is geographically accessible, the waiting lists are unconscionably long and obviously priority must be given to children who are most severely disturbed.

In the Final Report of its three year study, the Joint Commission on Mental Health of Children (1970) reported that close to a million and a half children in the United States were suffering from severe mental illness. Of this number, less than one-third received some type of treatment and in at least one-half of these cases the treatment was completely inadequate. These statistics refer only to seriously disturbed children. There are an additional 10 to 12 percent who manage to attend school even with emotional problems; of this group less than one percent receive some type of psychological service. Disregarding the earliest symptoms of problem behavior is probably related to the fact that over a half million children are brought before the courts each year. Judge Bazelon, a member of the Joint Commission, noted that juvenile courts and correctional institutions failed even to begin to meet the needs of these emotionally-disturbed children.

Aside from the cost in human lives, which is incalculable, this gross neglect eventually results in a tremendous property loss as well as the financial burden involved in maintaining a system of courts and correctional facilities. According to the President's Task Force (1970), mental illness costs more than 20 billion dollars a year.

These statistics are particularly tragic in that so much is known about the etiology and prevention of mental disturbance. Yolles, Director of the National Institute of Mental Health (1970) notes: "In mental health, more so perhaps than in any other area of public health, the bases of adult well-being or illness are laid in childhood... indeed, the origins of some of the most severe mental and emotional

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illnesses may be tracked to the early physical and emotional experiences of the child's world." The present study was designed to speak, in some small way, to this problem. The focus was on intervention at the point of incipient disturbance, and at an age where the amount of effort expended can hope to have the maximum impact.

Review of Literature

Concern for the mental health of disadvantaged preschool children is a comparatively recent phenomena, closely associated with the increasing attention to the importance of early stimulation. An important source of input in dealing with the problems of emotional disturbance is drawn from the learning theory of B. F. Skinner. Although there was a long tradition of research which attempted to apply Pavlovian conditioning to psychotherapy (see Hilgard & Marquis, 1940), the classical approach did not seem relevant to learning situations with young children. The application of Skinnerian theory to classroom behavior got off to a slow start but gathered considerable impetus with the publications of Keller & Schoenfeld (1950) and Skinner (1953). At about the same time, the relevance of operant conditioning principles in psychotherapy was pointed up by the work of Dollard & Miller (1950). These principles seemed to be particularly useful in studying the development of normal behavior (Bijou, 1955; Bijou & Baer, 1961), but the most dramatic results were obtained in work with emotionally disturbed children.

In 1956, Azrin & Lindsley used operant conditioning procedures to increase cooperation between children; Williams (1959) demonstrated the effectiveness of these techniques in eliminating tantrum behavior; and in 1959 Ayllon & Michael described the psychiatric nurse as a "behavioral engineer." More recently, the journals have called attention to the dramatic results obtained by using operant principles with autistic children, especially the work of Lovaas (e.g. Lovaas, Berberich, Perloff & Schaeffer, 1966). Hewett (1968) reports the use of behavior modification with somewhat less disturbed children in what he has called an "engineered" classroom. Other investigators have used the operant conditioning approach with preschool children (e.g. Walters, Pearce & Dahms, 1957; Homme, de Baca, Devine, Steinhorst & Rickert, 1963), but these have been in special research contexts, with trained personnel and primarily with children from the middle socioeconomic strata.

The greatest awareness of the extent of emotional problems among preschoolers has undoubtedly come from observations of thousands of disadvantaged children enrolled in the Head Start program. With the mushrooming interest in schooling for young children, the lack of adequately trained personnel to deal with the special needs of this population have become evident. In 1965, the National Institute of Mental Health, through its Training and Manpower Resources Branch, funded four pilot programs for the training of preschool teachers in therapeutic procedures. Braun & Lasher (1970) report the course of one of these, at Tufts University. Additional centers were located at Wheelock College, University of Michigan, and Cedars-Sinai Medical Center. For the most part, these training programs use a psychodynamic framework derived from psychoanalytic theory.

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In a sense the present study demonstrates ways in which the graduates of such programs may be profitably employed, either as therapist-aides in a regular Head Start setting or as teachers in special classes for disturbed children.

Overview of Both Studies

Two separate but related studies were carried out. Experiment I compared three methods of dealing with identified emotionally-disturbed children, simultaneously testing the hypothesis that community personnel can be taught to work effectively with such children. Experiment II was concerned with the question of whether children from different socioeconomic and ethnic groups demonstrate similar types of problem behaviors.

Theoretical Framework. In both Experiment I and Experiment II, a similar theoretical orientation prevailed. The director of one of the therapeutic preschools had completed the program at Cedars-Sinai and had actually taken her practicum at the other clinic preschool used in this investigation. Thus the significant personnel in both experimental investigations shared a common philosophy regarding the treatment of emotional problems with young children.

Under this basic psychodynamic approach, disturbed children are perceived as being unable to profit either cognitively or emotionally from their preschool experiences. The child's social behavior, his inability to cope with adults and peers, is perceived as reflecting a lack of trust, which is often not unrelated to his real life situation. Even the nurturing nursery environment seems threatening and unpredictable. Within this context, aggressive behavior is interpreted as the child's attempts to test the limits of the new adult-controlled setting, in a sense tempting the imposition of those punishments and sanctions with which he is familiar. At the other extreme, withdrawn behavior is viewed as evidence of a paralyzing fear of making any type of response so as to avoid incurring dreadful reprisals.

The workers in both experiments operated under the assumption that the greatest need of every disturbed child is to develop a sense of self and the ability to place trust in others. Theoretically, the sense of self in the infant develops within the context of a dynamic relationship with a caretaking adult, whose presence and concern has been established and can thus be relied on and trusted. A disturbed child has not internalized this developmental phase and must have the experience of being with an accepting adult who will permit him to regress temporarily to infantile behavior. The role of the therapist in the preschool situation would be to assist the child in passing through the necessary developmental levels. The supporting adult also acts as an intermediary for the child, interpreting rules, verbal and physical interactions, and routines so as to provide guidelines for responding appropriately to environmental cues. Thus, by example, and instruction, the adult serves as a model for fostering appropriate social behavior.

EXPERIMENT I

The major purpose of this investigation was to evaluate the comparative effectiveness of three methods of working with emotionally-disturbed Head Start children. The following hypotheses were tested:

1. After a short training period,[1] paraprofessional aides selected from populations similar to those from which the children are drawn, working with a child on an individual basis two mornings a week, will be able to effect measurable decrement in problem behaviors as well as improvement in cognitive functioning.

2. A Head Start teacher with special training[2] for work with emotionally disturbed preschoolers, working with individual children in a special playroom at the regular Head Start site, will produce decrement in problem behaviors as well as improvement in cognitive functioning.

3. Disturbed children removed from their regular Head Start class and bussed to a special therapeutic preschool under Head Start auspices, with a seven-to-two child-adult ratio, will demonstrate measurable decrement in problem behaviors as well as improvement in cognitive functioning.

4. Disturbed children receiving any of these three interventions will show less disturbance and more cognitive gain than disturbed children in the same Head Start class who do not receive intervention.

5. Compared to normal controls, on the pretest all disturbed children will demonstrate more problem behavior and be inferior in intellectual functioning; those who receive any of the experimental interventions will approach normal levels after treatment, whereas untreated disturbed children will remain measurably different or drop out of the class.

These five hypotheses were tested with five treatment groups which for convenience have been given the following labels:

1. Paraprofessional; 2. Therapist; 3. Special Class; 4. Untreated Disturbed; and 5. Normal Control. Groups 1, 2, and 3 taken together have been designated Treated Disturbed.

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[1] See Appendixes A & B.

[2] See Appendix C.

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Method

Subjects

As originally planned, the entire study was to be carried out with the population of a single Delegate Agency. This agency also operates two special therapeutic Head Start classes and is particularly interested in serving the needs of disturbed children. During 1968-69 the agency had found that the 14 places available in the two special classes were insufficient and had suggested a research study to examine alternative procedures for helping these children. The experimental design required the regular Head Start teachers to identify all the emotionally-disturbed children in their classrooms, administer a screening instrument, and assign children to the three treatment conditions using a stratified random procedure. However, it soon became evident that the number of referrals were running far below expectation. It was obviously unreasonable to expect the agency to work with only one of the three children who were referred by October 1st. These children were thus transferred immediately to the special site, where there were four adults employed to work with them. A second Head Start agency, operating classes with a similar population, was contacted and, after several meetings with agency personnel, arrangements were made for identification of additional subjects. The two classes in the first agency were still included to represent the Special Class used as the third treatment.

Every teacher in the second agency was asked to identify all the children in her class who needed special attention. The teachers were then requested to rate these children, using the UCLA-ECRC modification of the Kohn Problem Checklist and Competence Scale. The scores on the completed protocols were arranged in order from most to least disturbed and stratified random assignment to treatment was made, with the following stipulation: in each class where there was one child assigned to a treatment condition there must also be one child assigned to the disturbed control group. The rationale for this procedure was to minimize as much as possible the inter-class and inter-teacher effect, which has always been demonstrated as introducing a powerful source of variance.

In addition, in every class in which a disturbed child had been assigned to treatment, two children were selected on the basis of a table of random numbers. The teachers were also requested to rate these children on the Problem Checklist and Competence Scale. These randomly selected children constituted the Normal Control group.

Of the total population of 68 children who were screened, 42 (24 boys and 18 girls) were identified as disturbed and distributed among the treatments as follows: Paraprofessional, 6; Therapist, 7; Special Class, 15; Disturbed Control, 14. The remaining 26 children (13 boys and 13 girls) were in the Normal Control group.

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Criterion Measures

Although the format for presentation and the wording of some of the items were slightly modified, the instrument for identifying

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children as disturbed was essentially the 1967 version of the Kohn Problem Checklist and Competence Scale. The Problem Checklist was reduced from 51 to 47 items and the 75-item Competence Scale to 69.

Two factors have been identified with both scales. For the Problem Checklist, Factor I represents Apathy-Withdrawal and Factor II Anger-Defiance. On the Competence Scale, a high score on Factor I represents Interest-Participation, a low score Apathy-Withdrawal; a high score on Factor II indicates Cooperation-Compliance, a low score Anger-Defiance.

Of the 47 items on the Problem Checklist, 24 fall under Factor I and 23 under Factor II. Since each item is rated from 1 (not at all typical) to 3 (very typical), the maximum scores for Factor I and Factor II are 72 and 69, respectively, with the high score indicating increased disturbance. For the Competence Scale there are 36 items in Factor I and 33 in Factor II; ratings are on a seven-point scale, with top scores of 252 and 231, respectively. Although there are some positively and some negatively worded items, the scoring is adjusted so that all items are scored in the positive direction. (Appendix D presents the Examiner's Manual and the Record Form used as the screening instrument.)

Kohn (1968) found a high negative correlation between the Factor I and Factor II scores on the two scales. Thus, as social competence scores decrease, problem symptoms increase, with a great deal more room for variability in social competence still being within the normal behavior range. In essence, the Checklist is more sensitive to the identification of aberrant behavior and was used as the basic criterion for identifying disturbed children, with the Competence Scale serving primarily as corroboration.

Cognitive measures to evaluate intellectual functioning included the Peabody Picture Vocabulary Test, the Goodenough Draw-a-Man Test, and the Caldwell Preschool Inventory.

Additional information on individual children as well as teacher characteristics was obtained with the Individual OSCI, an observation instrument developed at the UCLA-ECRC when it was part of the national Head Start evaluation network. (See Appendix E for OSCI Manual and Record Form.) Progress of therapy was also monitored with periodic videotaping of the disturbed children in interactions with their peers, special aides, or classroom personnel.

Some information on the family background of the children was to have been derived from the Biodata Form, developed at the Center, as well as responses to several attitude measures designed specifically for this population. However, conferences with the agency personnel revealed very strong antagonism to anyone but the social workers of the agency visiting the homes or interviewing parents. A compromise was agreed upon, in which the social worker or her assistant would obtain the needed data. In spite of many requests, and replacements of several sets of "lost" protocols, the necessary measures were never completed.

Procedure

Paraprofessional Treatment:[1] Six of the disturbed children were randomly assigned to three paraprofessional aides. Each aide worked with two children, on two alternate days, for example Monday and Wednesday with one child and Tuesday and Thursday with the other. On the fifth day there was an in-service meeting at the Center office, at which time the progress of the individual children was discussed, problems described, and future lines of procedure delineated. At the site, the aide spent all her time with the child within the context of the regular classroom activities, remaining with the child through the noon meal period.

Standard Head Start materials were used in the intervention both as a vehicle for encouraging interaction with peers so as to provide a basis for acceptance into the group, and as a way in which the child could externalize areas of emotional conflict in an accepting context. For example, paint provides a medium for symbolic representation as well as a source of sensual and sensory expression. Working with clay offers an opportunity for hitting and pounding without fear of reprisal, and is thus an acceptable aggressive outlet; it also serves as an outlet for creative and destructive inpulses. Doll corner activities present excellent opportunities for role-playing and socialization.

The paraprofessional aide helped the child by providing support in the exploration of the use of the various types of materials, especially when the child came into conflict with peers. The aide did not participate in these activities, but if the child were frustrated and unable to cope, she would intervene and interpret what had happened. In some cases where the child was the object of aggression by other children, she could help the child find ways to protect his own rights. Occasionally it would be necessary for the aide to remove the child from a large group activity and find a quiet corner of the classroom where the child would be able to function. Sometimes it seemed that the child needed to regress before more mature patterns could develop. In such cases the aide was able to provide an environment in which regression was permissible; this might mean holding the child in her lap and offering a nursing bottle together with comfort and soothing reassurance.

By example and instruction the aide helped the child understand his motivations and needs and how to satisfy them in a socially-acceptable manner. Within the guidelines of the psychodynamic theoretical framework, the type of support provided was idiosyncratic to the needs of the individual child. Some flavor of the nature of the intervention can be obtained from the anecdotal records, considerably condensed and paraphrased, in Appendix F.

Therapist Treatment. In the screening process it was discovered that at one site with three classes there were 6 children who could

[1] See Appendixes A and B for discussion of selection and training of paraprofessionals.

be characterized as emotionally disturbed, and there was a good deal of pressure from the agency to work with these children. To maintain a high level of cooperation, it was decided to provide the desired service and at the same time test an alternative therapeutic procedure.

A trained therapist,[1] was assigned to this site to work with these six children. Although the professional background of the therapist was far more extensive than that of the paraprofessional aides, she received the same six-week training at the Center, followed the same basic guidelines, and participated in the weekly meetings. Together with the study supervisor, who had had the same special course for teachers of disturbed preschool children, she served as a group leader in the weekly discussion sessions. Thus, while the details of the setting differed, the therapeutic approach was basically similar to that adopted by the paraprofessional treatment group.

A small room at the site, approximately eight feet square, had been set aside and furnished as a special playroom for the disturbed children. In this room there were play dough, clay, paint and various art supplies, water for water play and doll bath, doll crib, nursing bottles, doll dishes, dress-up clothes, make-up, nail polish, telephones, tape recorder, blocks, Flagg dolls, hammers, nails, wood scraps and other building materials, and a punching bag.

The therapist worked with each child on a one-to-one basis for a half-an-hour a day, four days a week. Appropriate materials for a particular child were set out before the therapist brought the child into the playroom, so that the child was able to find something upon which to focus his attention. Some children would flit from one activity to another in rapid succession, others would perseverate with the same activity for the entire session. Some children required a great deal of verbal and physical contact with the therapist, while others seemed to be unaware of her presence.

While the general atmosphere was one of adult non-intervention, the therapist occasionally helped the child accept her own feelings. For example, after a play session with dolls that was particularly hostile in quality, the therapist remarked: "It worries you when you get mad." The child stretched out on a box as if asleep. The therapist continued: "You know, sometimes I think you play tricks. You pretend you are asleep when you want to stop talking to people." The child smiled broadly at this remark and jumped up. Two days later, while in a relaxed interaction with the therapist, the child said: "I like to play tricks," and laughed. The anecdotal records in Appendix F provide further illustrations of this treatment.

In several cases there was a great deal of hesitancy about entering the playroom and it seemed easier to make the transition when

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[1] See Appendix C for a brief description of the training program.

accompanied by another child. Also, with two children in the therapy session it was possible to work out interpersonal problems, which did not arise when one child was alone with the therapist. The therapist was allowed a good deal of latitude in deciding whether to work with one or two children, but over the entire intervention period each child experienced approximately the same number of both types of sessions.

One of the original group of six children who began in December moved away at the beginning of January. A second child began to function on a much higher level in the classroom and was terminated in March. A new child was picked up in January and another began in mid-February but, because of a good deal of resistance from her classroom teacher, was dropped toward the end of April.

Special Class. The children in this group were removed from their regular Head Start classes and bussed to a special site set up for disturbed children. Each of the two classes consisted of from one to four children until the beginning of November. During this month two more children were brought in, so that the total population for the first semester was only 10 children in two classes. In January, one of the first two entrants was returned to the regular class and five more children enrolled. Only in the second semester did the class size reach the prescribed enrollment. However, there was considerable attrition so that only nine children were available for posttesting in May.

The intervention provided by the four adults in these two classes was not under the control of the Center staff, although there was good rapport with the agency personnel. Thus this group should be considered as another type of comparison rather than an experimental treatment. Classroom observations and videotaping were carried out to provide some way of assessing the therapeutic approach adopted in this intervention.

Results

Problem Checklist and Competence Scale

Since it had been the teacher who selected and rated those children who she felt would demonstrate either problem or normal behaviors on the Problem Checklist and Competence Scale, it was important to determine at the outset whether those children identified as having problem behaviors actually differed from their normal peers. Accordingly, Fisher t-tests were computed on mean scores, separately for Factors 1 and 2 of the screening instrument. The means and standard deviations, as well as the comparisons between groups, are presented in Table 1. The results of these tests confirm that the two groups of children demonstrated several critical areas of difference prior to the initiation of treatment.

The two groups differed significantly ($p < .001$) on both factors of the Problem Checklist in that, as a group, those children whom the

TABLE 1

Pre-treatment Means and Standard Deviations
on Problem Checklist and Competence Scale
by Treatment Group

Group		Problem Checklist[a]		Competence Scale[b]	
		Factor 1	Factor 2	Factor 1	Factor 2
Paraprofessional (N=6)	Mean	40.0	47.7	124.0	130.0
	S.D.	13.1	13.2	11.3	23.0
Therapist (N=7)	Mean	42.3	35.6	129.7	112.6
	S.D.	12.3	11.3	11.7	25.1
Special Class (N=14)	Mean	41.6	43.2	129.4	115.5
	S.D.	15.5	13.3	8.5	26.2
Untreated Disturbed[c] (N=13)	Mean	41.0	36.9	132.6	109.4
	S.D.	11.1	10.1	11.8	27.2
Total Disturbed (N=40)	Mean	41.3	40.8	129.7	115.2
	S.D.	12.8	12.3	10.6	25.8
Normal Control (N=21)	Mean	28.1	27.8	137.9	97.7
	S.D.	6.3	6.0	12.6	15.6
t-test[d] (d.f.=59)		-4.46	-4.55	2.67	-2.83
p-value[e]		p<.001	p<.001	p<.005	p<.005

[a]Higher score indicates greater disturbance.

[b]Higher score indicates greater social competence.

[c]Untreated Disturbed here includes "Demand" group.

[d]Total Disturbed vs Normal Control: Positive value indicates Normal Control has higher score than Treated Disturbed.

[e]All p-values are for one-tailed tests.

teachers had selected as demonstrating problem behaviors were rated as presenting both more apathy and withdrawal, and more anger and defiance, than those designated as normal.

On the Competence Scale, the normal and disturbed children also differed significantly on their total scores for Factors 1 and 2. That is, on Factor 1, the disturbed children were significantly ($p<.005$) more withdrawn and apathetic, whereas the normal children showed greater interest and participation in the school environment; on Factor 2, the disturbed children were significantly ($p<.005$) more compliant and passive than the normal children, who were more apt to demonstrate aggressive behavior. Thus, in social competence, those preschool children identified as emotionally disturbed by their teachers tended to be apathetic, withdrawn, and compliant, whereas those selected as being socially competent tended to be interested in activities and to participate aggressively in them. These results are consistent with the findings of Kohn (1968) which indicate that preschool teachers are more apt to rate those children who are withdrawn as maladjusted rather than those who are acting out.

Given that the disturbed children differed from the normals at the time of selection, the question remains as to whether the Treated Disturbed (Paraprofessional, Therapist, and Special Class), the Untreated Disturbed, and the Normal Control groups differed from one another. Four separate one-way analyses of variance were carried out comparing the five group means. As can be seen in Table 2, significant F-ratios

TABLE 2

Summary of One-Way Analyses of Variance for Pre-treatment Factor Means on Problem Checklist and Competence Scale

Variable	Factor	Mean Square	Error	F
		d.f. 4	56	
Problem Checklist	1	607.11	127.43	4.76**
Problem Checklist	2	740.96	104.61	7.08**
Competence Scale	1	305.68	129.51	2.36
Competence Scale	2	1500.44	518.83	2.89*

*$p<.05$; **$p<.01$.

were obtained on both factors of the Problem Checklist and for Factor 2 of the Competence Scale. Within each analysis, Newman-Keuls tests on differences between all pair-wise comparisons indicated that, for Factor 2 of the Checklist, the Paraprofessional and the Special Class groups were significantly ($p<.01$) more acting out than the Normal Control, whereas for Factor 2 of the Competence Scale only the Paraprofessional group was significantly ($p<.05$) more acting out than the Normal group. Newman-Keuls comparisons for Factor 1 of the Checklist did not yield any statistically significant differences between groups.

To determine the general effect of the intervention, teacher ratings of disturbed and control groups on the screening instrument at the end of the year were compared. These results are presented in Table 3. This table includes a fourth treatment group which requires some explanation.

Some of the identified disturbed children who had been designated Untreated Disturbed to serve as controls for those receiving treatment in the same classrooms were becoming more severe problems and the teachers demanded that the children receive help. They were understandably more concerned with responding to the needs of the children than the requirements of experimental research. Thus in February two of the children were assigned on an individual basis to two trainees in the special Cedars-Sinai program. Later, in March and April, as the children being worked with by the paraprofessional aides began to demonstrate that they were able to cope in the classroom, although not at the optimum level, they were gradually phased out and five severely disturbed children assigned to the paraprofessional aides. These seven children, who were originally classified as Untreated Disturbed, have been labeled the "Demand" group.

When the "Demand" group was included in the total group of Treated children and compared with the remaining Untreated Disturbed, no differences for Factor 1 or 2 on either of the two scales were found. Also, when the "Demand"-plus-Treated group was compared to the Normal Control there was no significant difference on Factor 1 of the Competence Scale, indicating that the disturbed children appeared to be like their normal peers in terms of participation in school activities. However, there were significant differences between these two groups on Factor 2 of the Competence Scale and on Factors 1 and 2 of the Checklist. Thus, following the intervention, the total Treated group continued to demonstrate more problem behaviors than the Normals. However, it should be emphasized that the most severely disturbed children had been removed from the Untreated and placed in the Treated category, doubling the odds against the Treated group. That is, the children remaining in the untreated group were obviously less disturbed since their teachers did not feel it necessary to seek special help, while the inclusion of the most severely disturbed controls, who could not be expected to show much change in the short two-to-three week period, served to dilute the treatment effect on the children receiving the longer intervention.

To determine the differential effect of the various treatments, the post intervention mean ratings for each group, presented in Table 3,

TABLE 3

Post-treatment Means and Standard Deviations
on Problem Checklist and Competence Scale
by Treatment Groups

Group		Problem Checklist		Competence Scale	
		Factor 1	Factor 2	Factor 1	Factor 2
Paraprofessional (N=6)	Mean	31.2	39.0	135.7	116.3
	S.D.	6.3	12.2	2.4	19.1
Therapist (N=7)	Mean	31.1	34.0	129.4	107.0
	S.D.	6.1	9.6	19.5	18.9
Special Class (N=14)	Mean	30.2	35.8	143.1	109.9
	S.D.	5.2	7.4	7.6	18.7
Demand Group (N=6)	Mean	38.7	44.8	133.3	127.0
	S.D.	6.1	12.9	17.0	28.9
Treated Disturbed (Total N=33)	Mean	32.1	37.6	137.1	113.6
	S.D.	6.3	10.2	13.1	21.1
Untreated Disturbed (N=7)	Mean	36.0	31.4	133.0	105.3
	S.D.	10.5	8.6	7.2	21.0
Normal Control (N=21)	Mean	28.0	30.4	137.6	103.2
	S.D.	5.1	9.4	10.5	19.5
t-test[a]		-.99	1.68	1.15	.95
t-test[b] (d.f.=52)		-2.64	-2.69	.16	-1.85
p-value (one-tailed test)		$p<.01$	$p<.005$	$p>.05$	$p<.05$

[a]Treated Disturbed vs Untreated Disturbed. None of these values were significant.

[b]Treated Disturbed vs Normal Controls.

were subjected to separate one-way analyses of variance for each factor. These indicated (see Table 4) that the group means differed on Factors 1

TABLE 4

Summary of One-Way Analyses of Variance for Post-treatment Factor Means on Problem Checklist and Competence Scale

		Mean Square	Error	F
Variable	Factor	d.f. 5	55	
Problem Checklist	1	144.86	38.72	3.74**
Problem Checklist	2	241.81	91.60	2.64*
Competence Scale	1	224.87	127.94	1.76
Competence Scale	2	622.38	417.11	1.49

*p<.05; **p<.01.

and 2 of the Checklist. For these two factors, Newman-Keuls tests on differences between all pair-wise comparisons of means showed that only the "Demand" group was rated as exhibiting more problem behaviors at the end of treatment than the Normals. That is, the only children who were significantly different from the normal children at the conclusion of treatment were those for whom treatment was initiated in the middle of the second semester on the demand of the teacher who could no longer cope with a particularly disturbed child. There were no differences among the group means on Factor 1 or 2 of the Competence Scale, indicating that, regardless of treatment or control condition, the disturbed children were seen to be as socially competent as the normal children.

Cognitive Measures

The Peabody Picture Vocabulary Test, the Goodenough Draw-a-Man Test, and the Caldwell Preschool Inventory were administered as pre and post measures to all the disturbed children. The Normal Controls received only the Caldwell as a measure of intellectual functioning. For the first two instruments, the score used was the derived I.Q. For the Caldwell, since the children in the Special Class treatment had been given the 64 item form and all the other children the 85 item one, the value used in the comparative analyses was the percent correct. Pre and post treatment means and standard deviations on these three instruments for each of the treatment and control groups are presented in Table 5.

TABLE 5

Pre- and Post-treatment Means and Standard Deviations on Cognitive Variables, by Treatments

		PPVT		Goodenough		Caldwell[b]	
		Pre	Post	Pre	Post	Pre	Post
Paraprofessional (N=6)	Mean	68.5	86.2	62.7	65.0	39.0	57.8
	S.D.	14.3	10.6	6.9	10.2	29.7	28.5
Therapist (N=7)	Mean	67.9	81.4	61.4	66.0	39.7	74.0
	S.D.	20.3	25.4	7.9	6.4	6.7	25.01
Special Class (N=9)	Mean	76.7	87.9	72.1	71.4	48.8	52.5
	S.D.	11.5	12.4	11.3	9.1	16.7	17.9
Demand (N=7)	Mean	68.1	73.6	63.9	70.1	25.0	53.3
	S.D.	21.9	21.5	14.3	7.8	26.1	27.5
Untreated Disturbed (N=6)	Mean	71.0	86.5	75.0	76.5	25.3	53.8
	S.D.	20.9	22.5	16.1	15.7	19.4	24.5
Disturbed[a]	Mean	70.8	82.4	67.2	68.5	36.7	57.4
	S.D.	17.2	18.3	12.3	8.5	20.8	22.8
Normal Control (N=12)	Mean					48.4	80.0
	S.D.					12.9	12.5

[a]Pre means are for total disturbed (N=35 for PPVT and Goodenough; N=23 for Caldwell. Post means are for treated disturbed (N=29 for PPVT and Goodenough; N=19 for Caldwell).

[b]Pre-post Caldwell scores were not available for all Disturbed children. The N's for the first five groups in this column are 5, 3, 8, 3, and 4.

To determine whether there were any differences on the PPVT and the Goodenough among the disturbed children prior to assignment to treatments, one-way analyses of variance were computed (Table 6). These

TABLE 6

Summary of One-Way Analyses of Variance
for Pre- and Post-treatment Means on Cognitive Variables

Variable	d.f.	Mean Square	d.f.	Error	F
PPVT[a] (Pretest)	3	141.79	31	310.24	.46
PPVT[b] (Posttest)	4	248.63	30	365.19	.68
Goodenough[a] (Pretest)	3	182.2	31	148.9	1.22
Goodenough[b] (Posttest)	4	133.43	30	101.09	1.32
Caldwell[c] (Pretest)	4	722.96	30	329.24	2.20*
Caldwell[d] (Posttest)	5	1072.89	29	405.59	2.65*

[a]"Demand" group part of Untreated Disturbed.

[b]"Demand" group as separate treatment group.

[c]"Demand" group part of Untreated Disturbed; includes Normal Control.

[d]"Demand" group as separate treatment group; includes Normal Control.

*$p < .05$, one-tailed.

revealed no differences among the five groups. Since these tests had not been administered to the Normal Control, there was no way of comparing their scores with those of the disturbed children. However, on the basis of test results from hundreds of children from similar populations, it is quite safe to presume that the normal children would have obtained significantly superior scores compared to the disturbed children.

Additional support for this assumption is that on the pre-Caldwell where data is available for both groups, a one-tailed t-test comparing all disturbed children with normals showed a significant difference in favor of the normal group ($t=1.77$, 33 d.f., $p < .05$). This was true in spite of the fact that the disturbed children in the Special Class had been given a much shorter form of the Caldwell and their mean score of

48.8% was even higher than that of the Normal Controls. It should also be noted that the children in the Special Class were tested by trained examiners from the Center staff, who had a great deal of patience and often gave the test in two sessions, whereas the longer form was given by the teachers in one sitting. To compare the effect of the different treatments on children's acquisition of academic skills, separate one-way analyses of variance were carried out on the posttest scores for each of these three cognitive measures (Table 6). Again no differences were found among the groups of disturbed children for the PPVT or the Goodenough. On the Caldwell, where posttest scores for the normal controls were available, a two-tailed t-test comparing all treated disturbed children with normals indicated the treated children still scored at a significantly lower level ($t=3.57$, 19 d.f., $p<.01$). When the scores of each of the treated disturbed groups were taken separately and compared with the normal controls, the F-ratio was significant at the .05 level, but the Newman-Keuls post hoc pair-wise comparisons revealed no one group to be significantly different from another.

Observation of Substantive Curricular Interactions (OSCI)

Since teacher characteristics and classroom environments can make an important difference in the effectiveness of a particular treatment, it was necessary to observe both how much diffusion occurred in terms of interactions with normal and disturbed non-treatment children and to what extent the classroom teacher adopted some of the procedures employed by the therapist. To obtain this type of information, the classroom observation instrument (OSCI), developed for the National Head Start Evaluation by the UCLA Head Start Evaluation and Research Center, was modified so as to utilize the behaviors of individual children to provide a composite picture of the classroom ambience. The scope and variety of information recorded can be gleaned from Table 7.

Problems in arranging dates when the disturbed children could be observed without causing too much classroom disruption made it impossible to carry out, at comparable intervals over the treatment period, the number of observations which had been originally planned. Thus the data obtained represent only a very meager time-sample of any particular classroom, with many of the variables showing zero frequency of observed occurrence in many of the classes. Table 8 presents data for the 16 variables for which frequencies were recorded across most of the observations. A correlation matrix showing the relationship of these OSCI variables with each other and with the Caldwell (18), the PPVT (19), Goodenough (20), Factor 1 (21), and Factor 2 (22) of the Problem Checklist, and Factor 1 (23) and Factor 2 (24) of the Competence Scale is given in Table 9.

This matrix confirms the interrelatedness of many of the variables. For instance, the first four variables refer to groupings: either a child alone or with an adult, in a small or large group. Thus, it is logical that classes in which there were high frequencies for individual and small group activities did not often engage in large group activities.

TABLE 7

Observation of Substantive Curricular Interactions (OSCI)

Codebook

Column	Item Description	
1-6	I.D. Number	
7	Total Number of Observations	
8	Month of Observation	
9	Blank	
	Group Size	
10-11	Alone	(1)[a]
12-13	Adult Only	(2)
14-15	1-5 Children	(3)
16-17	6 and over	(4)
	Locus of Control	
18-19	Self	(5)
20-21	Adult	(6)
22-23	Peer	
	Choice of Activity	
24-25	Can't tell	
26-27	Self	(8)
28-29	Adult	(9)
	Involvement in Activity	
30-31	Active-Attentive	
32-33	Passive-Attentive	
34-35	Disruptive	
36-37	Passive-Preoccupied	
38-39	Uninvolved	
	Nature of Activity	
40-41	Routine	(10)
42-43	Uninvolved	(11)
44-45	Cognitive	(12)
46-47	Arts	(13)
48-49	Small Muscle-Sensory	(14)
50-51	Large Muscle	(15)
52-53	Physical Contact	(16)
54-55	Other	
	Interactions	
56-57	Minutes with no Interactions	
58-59	Interactions with Adult	
60-61	Interactions initiated by Child to Adult	
62-63	Interactions initiated by Adult to Child	(17)
64-65	Interactions with Peer	
66-67	Interactions initiated by Child to Peer	
68-69	Interactions initiated by Peer to Child	
	Total Child Behavior	
70-71	Friendly	
72-73	Hostile	
74-75	Neutral	
76-77	Unresponsive-Withdrawn	
78	Blank	
79	Observation Number	
80	Card #1	

[a]Numbers in parentheses refer to variables used in Table 8.

TABLE 7 (CONT.)

Observation of Substantive Curricular Interactions (OSCI)

Codebook

Column	Item Description	Column	Item Description
1-6	I.D. Number		Child Expression with Adult
7	Total Number of Observations	46-47	Bland
		48-49	Positive
		50-51	Negative
8	Month of Observation	52-53	Blank
9	Blank		Child Expression with Peer
	Child Interaction Behavior with Adult	54-55	Bland
		56-57	Positive
10-11	Friendly	58-59	Negative
12-13	Hostile	60-61	Blank
14-15	Neutral		
16-17	Unresponsive-Withdrawn		Child Behavior Outside Interaction
	Child Interaction Behavior with Peer	62-63	Positive
		64-65	Negative
18-19	Friendly	66-67	None
20-21	Hostile	68-69	Blank
22-23	Neutral		
24-25	Uninvolved-Withdrawn		Self-Stimulation
		70-71	Oral
	Adult Behavior	72-73	Other
26-27	Effusive		
28-29	Encouraging	74-75	Blank
30-31	Neutral		
32-33	Mild Disapproval	76	Race
34-35	Firm Disapproval		
36-37	Ignore	77	Sex
	Child Expression: Total	78	SES
38-39	Bland		
40-41	Positive	79	Observation Number
42-43	Negative		
44-45	Blank	80	Card #2

TABLE 8

Observation of Substantive Curricular Interactions (OSCI)
Means, Standard Deviations, and Significance of Differences on 16 Variables
by 15 Individual Classes and 3 Treatment Groups

Variables		Child Alone (1)		Child with Adult (2)		1-5 children (3)		6 or more children (4)	
Class/Treatment	N	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
1	6	22.3	29.3	--	--	49.7	41.7	27.7	40.0
2	3	28.0	19.1	11.0	19.1	61.0	19.1	--	--
3	2	--	--	25.0	11.3	65.0	11.3	--	--
4	7	26.1	27.0	7.1	13.0	47.6	29.2	19:0	33.8
5	14	15.5	20.1	7.2	14.2	42.7	38.2	34.5	33.6
6	8	37.6	29.0	16.6	19.8	20.9	21.3	24.9	37.5
7	3	39.0	25.5	22.3	38.7	38.7	41.8	--	--
8	3	5.7	9.8	33.3	16.5	44.3	41.8	16.7	28.9
9	4	29.3	35.5	--	--	62.3	28.2	8.3	16.5
10	2	8.5	12.0	8.5	12.0	49.5	70.0	33.5	47.4
Total Treatment 1	52	22.8	24.9	10.6	17.1	44.7	34.3	21.8	31.8
11	17	25.5	22.1	10.8	19.5	51.9	33.1	11.8	20.2
12	5	26.6	18.9	--	--	53.2	29.6	20.0	21.7
13	3	27.7	25.4	5.7	9.8	66.3	28.3	--	--
Total Treatment 2	25	26.0	21.0	8.0	15.9	53.9	31.1	12.0	19.5
14	23	25.3	25.5	7.9	12.1	67.3	28.0	--	--
15	22	28.0	23.8	24.2	27.4	39.4	26.9	8.3	18.3
Total Treatment 3	45	26.6	24.4	15.9	22.4	53.7	30.6	4.1	13.4
F-ratio[a]		0.79		1.83		1.48		2.13*	
F-ratio[b]		0.34		1.59		1.17		6.58**	

[a] d.f. = 14/107 for F-ratio by class.

[b] d.f. = 2/119 for F-ratio by treatment

* $p < .05$; ** $p < .01$.

TABLE 8 (CONT.)

Observation of Substantive Curricular Interactions (OSCI)
Means, Standard Deviations, and Significance of Differences on 16 Variables
by 15 Individual Classes and 3 Treatment Groups

Treatment		Locus of Control: Child		Locus of Control: Adult		Child Selects Activity		Adult Selects Activity	
Class #	N	(5) Mean	S.D.	(6) Mean	S.D.	(8) Mean	S.D.	(9) Mean	S.D.
1	6	33.3	33.2	66.3	32.8	36.0	32.3	30.3	39.7
2	3	66.3	33.0	27.7	25.4	77.0	38.1	22.3	38.7
3	2	--	--	99.0	--	--	--	33.5	23.3
4	7	45.1	33.9	54.7	34.1	64.0	25.8	21.4	28.5
5	14	42.6	34.8	55.8	34.7	45.1	32.7	34.4	29.4
6	8	54.1	32.8	41.5	36.4	56.0	39.4	22.9	25.1
7	3	66.3	33.0	33.3	33.5	77.3	25.0	--	--
8	3	44.3	41.8	55.3	41.3	66.3	28.3	16.7	28.9
9	4	79.0	15.3	20.8	15.8	54.0	33.8	8.3	16.5
10	2	58.0	58.0	41.5	58.7	74.5	34.6	25.0	35.4
Total Treatment 1	52	48.3	34.4	50.1	34.9	53.3	33.9	24.3	28.2
11	17	70.3	22.7	29.4	23.2	65.3	37.1	14.7	28.0
12	5	66.6	16.5	33.4	16.5	56.4	24.9	23.4	25.3
13	3	72.0	19.1	28.0	19.1	77.3	25.0	5.7	9.8
Total Treatment 2	25	69.8	20.6	30.0	20.9	65.0	33.3	15.3	25.7
14	23	44.7	31.2	55.0	31.4	54.0	33.4	27.5	30.3
15	22	49.1	31.3	49.0	31.2	68.6	31.9	13.6	19.0
Total Treatment 3	45	46.9	31.0	52.1	31.0	61.2	33.1	20.7	26.1
F-ratio[a]		1.75		1.74		1.32		0.88	
F-ratio[b]		5.17**		4.60*		1.24		0.95	

[a] d.f.=14/107 for F-ratio by class.

[b] d.f.=2/119 for F-ratio by treatment.

*p<.05; **p<.01.

TABLE 8 (CONT.)

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Observation of Substantive Curricular Interactions (OSCI)
Means, Standard Deviations, and Significance of Differences on 16 Variables
by 15 Individual Classes and 3 Treatment Groups

Treatment		Adult Initiates to Child		Nature of Activity					
				Routines		Uninvolved		Cognitive	
Class #	N	(17) Mean	S.D.	(10) Mean	S.D.	(11) Mean	S.D.	(12) Mean	S.D.
1	6	61.3	48.7	36.0	35.2	27.8	31.1	5.7	8.8
2	3	44.3	41.8	28.0	34.8	11.0	19.1	--	--
3	2	46.0	29.7	8.5	12.0	--	--	--	--
4	7	47.7	36.7	14.3	20.2	7.1	18.9	7.1	13.0
5	14	59.5	38.3	26.3	26.0	7.1	12.5	3.6	9.6
6	8	68.5	33.4	22.9	25.1	6.4	8.8	6.3	12.3
7	3	57.0	12.1	--	--	11.0	19.1	5.7	9.8
8	3	44.0	50.4	16.7	28.9	--	--	--	--
9	4	89.3	19.5	8.3	16.5	8.5	9.8	--	--
10	2	40.0	56.6	--	--	8.5	12.0	33.5	47.4
Total Treatment 1		58.6	36.7	20.2	25.2	9.3	16.6	5.2	12.6
11	17	65.0	40.1	4.0	7.4	14.8	24.2	1.9	8.0
12	5	59.4	54.2	16.8	20.4	20.0	13.7	--	--
13	3	91.0	13.9	28.0	34.8	5.7	9.8	--	--
Total Treatment 2		67.0	40.8	9.4	16.8	14.7	21.1	1.3	6.6
14	23	73.4	27.4	23.2	25.0	11.6	15.4	16.7	21.3
15	22	60.5	30.0	11.4	18.8	9.2	13.4	2.3	10.7
Total Treatment 3	45	67.1	29.1	17.4	22.7	10.4	14.3	9.6	18.3
F-ratio[a]		0.79		1.55		0.91		2.17*	
F-ratio[b]		0.87		1.90		0.89		2.93	

[a] d.f. 14,107 for F-ratio by class.

[b] d.f. 2,119 for F-ratio by treatment.

* $p < .05$

TABLE 8 (CONT.)

Observation of Substantive Curricular Interactions (OSCI)
Means, Standard Deviations, and Significance of Differences on 16 Variables
by 15 Individual Classes and 3 Treatment Groups

Treatment		Nature of Activity (cont.)						Physical Contact	
		Art		Sensory		Large Muscle			
Class #	N	(13) Mean	S.D.	(14) Mean	S.D.	(15) Mean	S.D.	(16) Mean	S.D.
1	6	16.7	21.1	2.8	6.9	8.3	20.4	2.8	6.9
2	3	11.0	19.1	11.0	19.1	33.3	43.8	5.7	9.8
3	2	91.0	11.3	--	--	--	--	--	--
4	7	45.0	42.3	2.4	6.4	16.6	31.8	2.4	6.4
5	14	32.0	27.9	20.2	26.2	8.3	16.9	--	--
6	8	8.4	17.8	6.4	8.8	33.4	29.7	14.5	20.7
7	3	39.0	34.8	--	--	16.7	28.9	5.7	9.8
8	3	11.0	19.1	16.7	28.9	11.0	19.1	5.7	9.8
9	4	4.3	8.5	12.5	25.0	50.0	36.0	--	--
10	2	49.5	70.0	--	--	--	--	8.5	12.0
Total Treatment 1		27.1	32.4	9.6	18.4	17.9	27.3	4.2	10.4
11	17	13.7	18.8	6.9	13.3	42.9	29.7	6.9	16.7
12	5	23.4	25.3	16.6	23.5	16.6	23.5	--	--
13	3	22.3	25.4	27.7	25.4	16.7	16.5	--	--
Total Treatment 2		16.7	20.4	11.4	17.8	34.5	29.4	4.7	14.1
14	23	9.4	16.5	9.4	15.7	21.7	19.7	2.2	5.9
15	22	19.7	22.2	18.9	30.0	26.5	22.7	3.8	8.8
Total Treatment 3	45	14.4	19.9	14.0	24.0	24.1	21.1	3.0	7.4
F-ratio[a]		3.20**		1.00		2.22*		1.13	
F-ratio[b]		3.15**		0.56		3.54*		0.26	

[a] d.f.=14/107 for F-ratio by class

[b] d.f.=2/119 for F-ratio by treatment.

*p<.05; **p<.01.

TABLE 9

Means, Standard Deviations, and Correlation Matrix on Selected Variables,[a] for Total Population

Var. No.	Mean	S.D.	N	1	13	14	15	16	18	19	20	21	22	23	24
					(13)	05	-59**	-23	03	17	28	-04	-01	-19	04
1	24.5	7.6	59	(1)		(14)	-25	-07	-47**	15	-11	-03	-08	25	-03
2	13.2	7.9	51	14	(2)		(15)	55**	35*	14	08	-05	-07	-20	-16
3	49.1	12.0	61	-16	-34*	(3)		(16)	46**	04	17	-01	-33*	11	-16
4	20.0	10.0	48	-52**	-56**	-29*	(4)		(18)	70**	49**	-32*	-16	27	-03
5	53.4	13.3	59	38**	02	22	-59**	(5)		(19)	35*	-33*	-13	42**	06
6	47.4	16.0	61	-41**	18	02	58**	-99**	(6)		(20)	-42**	-05	14	-09
8	58.6	11.1	59	26	43**	-02	-63**	51**	-51**	(8)		(21)	12	-34**	00
9	22.0	8.7	59	-45**	-34**	-09	96**	-74**	72**	-73**	(9)		(22)	-14	77**
17	62.8	12.4	61	45**	-29*	37**	-37**	49**	-53**	-16	-41**	(17)		(23)	11
10	18.0	9.2	57	-26	-30*	-13	81**	-72**	43**	-66**	61**	03	(10)		(24)
11	11.1	5.7	57	-04	07	22	-04	-12	15	-37**	13	-03	18	(11)	
12	7.1	7.3	49	-29*	-33*	44**	38**	-12	15	11	25	-13	35*	-07	(12)
13	24.0	18.0	61	-30*	01	01	49**	-28	59**	19	41**	-66**	-05	-28	16
14	12.0	7.2	55	-35**	21	-03	14	06	-08	12	-05	20	18	-41**	-29*
15	23.6	13.5	57	52**	14	13	-75**	79**	-80**	37**	-72**	52**	-79**	-07	-19
16	5.3	3.6	42	29	17	-69**	28	50**	-57**	16	-17	10	-15	-26	-06
18	63.5	22.9	35	44**	06	-18	-30*	37*	-37*	29	-37*	-06	-33*	00	-01
19	83.7	18.5	37	20	-02	15	-04	08	08	17	-03	06	00	07	26
20	70.9	10.9	37	13	-00	00	00	01	16	11	00	-10	-06	-17	28
21	32.2	8.5	60	-19	-14	-10	10	-03	-09	-03	05	-14	-04	13	-23
22	34.5	10.4	60	-05	-21	21	-07	-07	-00	05	-12	08	06	-10	21
23	136.9	11.7	60	11	13	05	14	-14	09	-01	05	26	43**	-04	44**
24	109.0	21.0	60	-12	-36**	16	20	-17	10	-13	12	08	19	-24	30*

*p<.05; **p<.01.

[a]See Table 7, page 18, for identification of variables 1-17. Variables 18-20 are described on page 17.

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Also, when small units prevailed, there was a greater opportunity for children to choose their own activities and to be in control; they seemed to have fewer routines or structured, teacher-directed, cognitive inputs, with little emphasis on art or small muscle activities. There was also a high correlation with large muscle activities, adult-to-child intiations, and high scores on the Caldwell. The larger groupings were positively related to teacher control, cognitive input, art, and routines; significant negative correlations were found with large muscle activities, adult-to-child initiations, and scores on the Caldwell.

It is reassuring to find an almost perfect negative correlation between the child-in-control and the adult-in-control variables; obviously these were mutually-exclusive. Similarly, there were extremely strong positive relationships between the frequency of large groupings and involvement in routines such as eating, clean-up, etc., and negative correlations between adult vs. child choice of activity. All of the above relationships were not unexpected; nor were the high positive correlations among the Caldwell, PPVT, and Goodenough. However, it was indeed surprising to find such a low (almost non-existent) correlation between frequency of cognitive input and any of the cognitive measures. Small groupings correlated negatively with cognitive input, which usually occurred in large group settings; small groupings also correlated positively with high Caldwell scores. It might be inferred that children are more apt to acquire usable information and skills when they are in an intimate relationship with an adult, where there is also a high degree of specific adult-to-child initiation.

On the whole, there seemed to be little relationship between how children were rated on the Kohn Problem Checklist or the Competence Scale and the kinds of groupings or activities in which they were observed in the classroom. Factor 1 (21) on the Problem Checklist showed high negative correlation with the three cognitive measures (18, 19, and 20) as well as with Factor 1 (23) of the Competence Scale. On the other hand, Factor 1 of the Competence Scale was positively correlated with routines, cognitive input, and score on PPVT. Factor 2 (22) on the Checklist was negatively related to physical contact (16), but positively to Factor 2 (24) of the Competence Scale. The latter variable was negatively related to small groupings but positively to cognitive input (12). Unfortunately the data available, even when all observations were pooled across treatments, were too sparse to warrant a factor analysis to determine common features of the most critical variables.

Looking at the OSCI data by specific class and treatment (Table 8), there were no significant differences for individual child, one child with one adult, or five or fewer children, types of groupings which occurred about 25% of the time. Because of the high variance, this was true even though for two of the 15 classes the frequency of individual or small groups was only 5.7% and 8.5%, respectively. On Variable 4, frequency of large groups, there was a significant difference across both classes and treatments.

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Newman-Keuls analyses of the treatment means for this variable revealed that the major difference was between Treatments 1 and 3 ($p<.01$); that between Treatments 1 and 2 was just below significance at the .05 level ($q=9.75$ where 10.98 is required). However, these findings seem to be related to the treatment conditions. In Treatment 1, where paraprofessionals worked with individual children in 10 different classes, the frequency of large groupings ranged from 8.3 to 34.5%. The therapist (Treatment 2) worked with children from three classes at one site where the predominant grouping included one-to-five children. Finally, Treatment 3 was carried out at the special site where there were never more than five children enrolled in one class.

The second area where significant differences were found was in locus of control. Since Variable 5 indicates the frequency with which the child controls the activity and Variable 6 the frequency of adult control, these are interrelated variables. In Treatment 2, where the child was in control almost 70% of the observed time, the teacher was in control only 30% of the time; in Treatments 1 and 3 there was a much more equitable division of child and adult control. In the analysis of variance for the child control variable, the differences among treatments was significant at the .01 level, with Treatment 2 showing significantly greater frequency of child control than either Treatment 1 or Treatment 2. However, for the adult control variable, significance was at the .05 level, with insufficient power to show between-group differences on the Newman-Keuls test.

In terms of the substantive curricular activities observed, only art showed significant differences at the .01 level across classes and treatments. However, the variances were so large that the Newman-Keuls test on individual means showed no significant differences for specific comparisons. In Treatment 1, one class was engaged in art 91% of the observed time, with the remainder of the time spent in routines (presumably clean-up). However, for the treatment group as a whole the average time spent in art activities was 27.1%, still considerably greater than the average for the other two treatments (16.7 and 14.4, respectively).

Conversely, the amount of time spent in large muscle activities was also significantly different (.05 level) across classes and treatments, with Treatment 1 showing considerably lower frequency than Treatments 2 and 3, but not sufficiently to attain between-group differences with the Newman-Keuls comparisons.

One class in Treatment 1 showed a mean score for cognitive involvement of 33.5%; the next highest score was a class in Treatment 3 which showed a frequency of 16.7%. The remaining 13 classes ranged from 1.9 to 9.6% in frequency of academic input. However, the overall F-ratio was only 2.17, significant at the .05 level, with no significant differences on the Newman-Keuls test of between-group means.

In brief, the major program and teacher differences were inherent in the particular treatments and there were few classroom variables to which changes in children across treatments could be attributed.

Discussion

Three of the five hypotheses were supported in that all three experimental procedures produced measurable improvement with disturbed children demonstrating fewer problem behaviors and improved cognitive functioning after comparatively brief periods of intervention. There was no statistical basis for identifying any one of the treatments as being superior to the others.

The fourth and fifth hypotheses could not be tested in this investigation. In the first place, although the decision to make random assignment of disturbed children from the same classroom to either a treatment or control group seemed to be an experimentally desirable procedure, it soon became evident that the so-called untreated disturbed children were in actuality benefitting in several ways. By providing a special aide for the disturbed children, as in the Paraprofessional treatment, or having a therapist remove one or two problem children to a special room, the regular teacher was able to give more attention to the disturbed control children in that class. In addition, on many occasions the experimental and control child in the same classroom became involved in an interaction which required the intervention of the paraprofessional aide. By her handling of these situations not only did she provide a therapeutic experience for the control child but also served as a model for the teacher, who was frequently observed using techniques introduced by the paraprofessionals or therapist. This diffusion, either through direct contact or modeling, meant that there were no children who could be considered truly uncontaminated controls.

Furthermore, early in the course of the second semester, several of the disturbed control children became so disruptive that it was impossible to retain them in the classroom without some type of special help. If these children had been dropped at this point it would have supported the fifth hypothesis; however, before this was permitted to occur, the natural, human concerns of teachers and agency personnel for the needs of the individual child overrode those of experimental rigor, and these most disturbed children were removed from the untreated control group and a new "demand" category was set up.

Also, to accommodate the needs of the highly disturbed children with the limited resources available, the paraprofessionals had to terminate their work with the disturbed children in the original experimental treatment group as soon as they demonstrated the ability to cope with the activities and interpersonal demands of the classroom society. For some of the children this meant that they had never really had the anticipated duration of the therapeutic intervention, and were posttested six to eight weeks after they had had their last treatment session.

In essence, then, there were no appropriate disturbed control children against whom to compare the children in the treatment groups. It is thus not surprising that there were no significant differences between the treated disturbed children when this group included the "demand" category and the control disturbed children when the most disturbed children were removed. Similarly, it is not surprising that there were

significant differences between the larger group of treated disturbed children and the normal control group. However, when all treatments are separately compared with the normal group, there is a significant difference which, by Newman-Keuls analysis, can be attributed solely to the greater number of problem behaviors of this "demand" group.

Subjective reports, some of which are reflected in Appendix F, indicate that the therapeutic interventions were far more successful than could be assumed from the test data alone. The Head Start teachers at first were highly suspicious of the research program and felt that the intervention by an "outsider" implied that they were in some way incompetent. However, when they saw the improvement in the behavior of the treated disturbed children, and recognized the insights they were gaining in their own work with the children, they were completely won over. This was demonstrated objectively in two ways. First, they were the most vocal in demanding similar help for the disturbed control children, and secondly, they requested that the therapy program be continued for the following year. Although it was impossible to institute a service program under a research funding, the insights gained from this first year led to a restatement of some of the basic hypotheses and the development of a new research proposal. The agency as well as the teachers at the various sites were eager to participate in the projected research investigation.

One of the insights gained from this preliminary study was the need to have complete cooperation at every level in order to make the optimum progress with the children. The only area in which this type of cooperation was lacking was with the social worker. Because of her attitude it was impossible to have more than a minimal contact with the parents of the children in the special program. All of the research personnel as well as the agency psychologist and the teachers felt that the work with the children would have been more effective if the parents had been involved. Thus, as an outgrowth of this study, a new research investigation was planned to determine within an experimental context the specific advantages which might accrue from a therapy program with a parent participation component.

The present study has also provided an affirmative response to the question of whether paraprofessional aides, recruited from the local community and without extensive professional preparation, can work effectively with disturbed children. While the no-difference finding among the three treatments is insufficient evidence for such an inference, the subjective reports from the field as well as the professional evaluation of the project supervisor were most favorable. In terms of the scope of the problem, the availability of trained professionals, and the economics of the situation, there seems no doubt that indigenous personnel, given a short but intensive training program, can indeed make an important contribution to this area.

EXPERIMENT II

The second study was designed to determine whether, and in what ways, emotionally disturbed children from white middle-class homes differ from their black lower-class peers. It is quite likely that many mental health workers, who receive the bulk of their training and experience with white middle-class clients, would be able to work more effectively if they had this type of information.

Method

Subjects

Clinic School A. The study supervisor and the therapist involved in Experiment I had both received their training at Cedars-Sinai, one of the NIMH funded centers for the training of therapeutic preschool teachers. They had established a good rapport with the staff of the therapeutic preschool associated with this center, and the Director of the preschool expressed her willingness to participate in a comparative study. The eight four-year-old children of the preschool (seven boys and one girl) constituted Clinic School A.

These children were primarily from the middle socioeconomic group. Their parents had either requested therapy for their children or been referred by their pediatricians. The presenting symptoms included extreme acting out behavior, inability to conform to parental expectations at home (usually including inability to manage normal eating and sleeping routines), or extreme timidity and passivity.

Over the years of functioning as a Head Start Evaluation and Research Center, the UCLA-ECRC had built up an excellent relationship with the administrative staff of an NIMH-funded Community Mental Health Center in the heart of a Black ghetto area. This Mental Health Center is a Delegate Agency for a group of Head Start classes and also administers a therapeutic preschool at the Mental Health Center. The chief psychiatrist had taken his specialization in Child Psychiatry at Cedars-Sinai, and the Head Start Coordinator, who also served as Director of this therapeutic preschool, had been trained under the NIMH program there. In contrast to Clinic School A, which operated on a year-round basis with major intake in June, Clinic School B was just getting started. However, the Director expected to have staff and a population of about 10 children before the end of September.

The children in Clinic School B were referred either by parents, surrogate parents, or social workers. There were 10 children enrolled; half of this number were living with foster parents who were being paid by a public agency to care for children whose own homes were inadequate.

The contrasting populations served by these two therapeutic preschools provided an ideal opportunity to determine whether children from different socioeconomic and ethnic groups presented characteristically different types of problem behaviors.

Procedure

This was basically an assessment study, so that no planned interventions were imposed over the therapy provided by the regular staff. However, since an additional question of interest was to explore whether therapeutic programs, administered by similarly-trained therapists, would be equally effective with children from these diverse populations, pre and posttesting as well as sample observations of the ongoing programs were planned.

Criterion Measures

All the instruments used in Experiment I were also administered in Experiment II. In addition, since both clinics operated under the assumption that parents of disturbed children need to be involved in the therapy process, an instrument to measure parental alienation, the "How I Feel" scale, was used.

Results

For Clinic School A, which had filled its quota of children before the beginning of the summer, the measures referred to here as pretests were administered in October, several months after the treatment had been initiated. At Clinic School B, where the subject population continued to trickle in even after the turn of the year, tests were given as soon as possible after admission. These differences should not be overlooked in evaluating the obtained test results.

Problem Checklist and Competence Scale

The teachers at Clinic School A made pre and post ratings on the Problem Checklist and Competence Scale of all the children in their classes. At Clinic School B, only post ratings were available. Thus a comparison of the kinds of problem behaviors manifested by children when initially enrolled at each of the two therapeutic preschools was not possible. The available pre and post ratings are presented in Table 10.

TABLE 10

Pre- and Post-treatment Means and Standard Deviations on Problem Checklist and Competence Scale

Group			Problem Checklist		Competence Scale	
			Factor 1	Factor 2	Factor 1	Factor 2
Clinic School A (N=8)	Pre	Mean	39.9	34.8	137.4	111.4
		S.D.	6.6	11.1	12.4	20.7
	Post	Mean	37.3	35.0	145.3	115.4
		S.D.	9.3	6.3	11.8	12.1
Clinic School B (N=10)	Post[a]	Mean	30.6	32.4	128.3	104.5
		S.D.	7.8	9.0	7.9	14.8

[a]No pretest ratings were available for the B group.

A set of t-tests comparing post Factor 1 and Factor 2 ratings on both the Problem Checklist and the Competence Scale for the two groups revealed no differences on Factor 1 ($t=1.64$, $p>.10$) or Factor 2 ($t=.71$, $p>.20$) of the Problem Checklist and Factor 2 of the Competence Scale ($t=1.70$, $p>.10$). There was a significant difference between the two groups on Factor 1 of the Competence Scale ($t=3.57$, $p<.01$), indicating that children in Clinic School B were rated as being more compliant and withdrawn than those in Clinic School A.

Cognitive Measures

The Peabody Picture Vocabulary Test, Goodenough Draw-A-Man Test, and Caldwell Preschool Inventory were administered as pre and posttests to the two Clinic School groups. For both the PPVT and the Goodenough, the derived I.Q. was used as the unit for analysis, while the percent correct was used as the score on the Caldwell. Pre and post group means, standard deviations, and test of significance for these three measures are presented in Table 11.

TABLE 11

Pre- and Post-treatment Means and Standard Deviations on Cognitive Variables, by Treatments

Group		PPVT		Goodenough		Caldwell	
		Pre	Post	Pre	Post	Pre	Post
Clinic School A	Mean	88.9	95.0	71.6	65.6	49.9	55.5
	S.D.	34.7	28.8	15.2	16.6	31.4	28.9
Clinic School B	Mean	81.7	88.2	70.5	70.8	77.2	75.7
	S.D.	15.3	21.3	10.4	11.5	15.0	16.0
		(N=9)		(N=8)		(N=6)	

The t-tests indicated no significant pretest differences between the two groups on any of these measures. Within each group there was a positive gain from pre to post treatment, but t-tests revealed no significant differences between the two groups on any of the three post measures. Thus, no statistically significant differences between these two groups on either intellectual functioning or school achievement were obtained.

"How I Feel" Scale

This measure was used to assess the degree of alienation of the parents of children with behavior problems. The instrument consisted of 30 items, with each alienated response given a value of 1 and each non-alienated response a 0. The means for the two groups (7.86, S.D. 4.41 and 9.38, S.D. 4.03, respectively) indicated that the responses of both groups reflected a relatively low degree of alienation. Welch's t-test indicated no statistically significant difference between the mean scores of the two groups ($t=.69$, 14 d.f., $p>.50$). Evidently these parents, who were actively involved in the therapy process with their children, did

not feel as powerless or lacking in ability to make a meaningful contribution to the solution of their own and their children's problems as has been found with other poverty populations.

Classroom Observation

To determine whether there were gross differences in the general program of activities provided at the two clinic preschools, the modified form of the Observation of Substantive Curricular Inputs (OSCI) was used. Table 12 presents the data on the 16 variables as described in Table 7, page 18, of this report. Here it can be seen that the only significant difference between the two preschools is in terms of group size. Thus, Clinic School A has only a limited amount of individual child activity whereas at Clinic School B this type of grouping was found in over 40% of the observations. Conversely, activity in large groups occurred frequently (41%) at Clinic School A but only rarely (2.4%) at Clinic School B. The correlation matrix presented in Table 9 would suggest that such grouping differences would also be reflected in differences in cognitive inputs (variable 12) but although the observed frequencies were in the predicted direction they were not large enough to attain statistical significance.

Discussion

With the current emphasis on treating black and white populations as unique cultural entities, requiring ethnically-matched personnel using distinctly different types of educational and therapeutic procedures, it seemed important to determine whether there was any objective basis for prescribing a separatist approach. While there were admittedly many inadequacies in the rigor with which Experiment II was carried out, and also accepting the fact that a no-difference finding is not a valid basis for assuming that differences would not have been found in a more tightly controlled study with a larger population, this investigation provided no support for the position that emotionally disturbed black ghetto children present inherently different problem behaviors compared to their white middle-class peers.

This is not meant to imply that the etiology of the problem behaviors are identical. Obviously the socioeconomic factors producing the traumatic conditions differ, and in some cases these differences may be critical, but more often the impact derives directly from the reality situation and not its cause. Thus, to the preschool child without a father it makes very little difference whether his father and mother are legally divorced or were never legally married; to the child who is left for most of his waking day with a caretaker it makes very little difference whether his mother is a highly-paid executive with a very active social life, or a household domestic.

There is not doubt that the effects of poverty are pervasive and devastating, but they make their effect through the people with whom the child comes into contact. In working with disturbed young children it seems far more realistic to obtain the help of a trained paraprofessional, regardless of color, and to address specific behavior problems, regardless of their origin.

TABLE 12

Observation of Substantive Curricular Interactions (OSCI)
Means, Standard Deviations, and Significance of Differences on 16 Variables
for Clinic School A and Clinic School B

	Clinic School A N=8		Clinic School B N=28		
	Mean	S.D.	Mean	S.D.	F-ratio[a]
1	10.4	29.3	42.6	35.9	5.37*
2	0.0	0.0	4.4	14.3	0.76
3	47.6	47.9	50.3	33.8	0.03
4	41.3	49.1	2.4	9.9	16.37**
5	31.0	45.4	58.0	36.0	3.13
6	68.1	45.3	41.5	36.2	3.01
8	37.2	43.9	63.4	32.0	3.51
9	41.4	41.4	32.1	33.7	0.43
17	59.8	30.0	55.4	35.4	0.10
10	16.5	35.3	29.8	30.1	1.12
11	0.0	0.0	14.4	19.1	4.44*
12	18.6	36.9	8.9	17.2	1.13
13	27.1	29.5	14.3	21.7	1.85
14	18.8	25.9	16.0	24.5	0.07
15	0.0	0.0	4.8	13.5	0.98
16	6.3	17.7	3.0	9.1	0.52

[a] d.f.=34.
* $p<.05$; ** $p<.01$.

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APPENDIX A

TRAINING OF PARAPROFESSIONALS

Three female paraprofessional aides, one Black and two Caucasian, were selected from the staff previously employed by the UCLA Head Start Evaluation and Research Center. None of these workers had had any professional training. One had only a high school diploma and the other two had one or two years of college. The Study Supervisor and the Therapist had been Head Start teachers and had subsequently received special training for working with emotionally disturbed preschool children (see Appendix B). All five project staff participated in a six-week daily training program, under the supervision of Dr. Joseph Edwards, Assistant Director of the UCLA-ECRC. During this period the Head Start teachers made referrals of children who needed special help, and the aides were assigned to visit the sites and write anecdotal records of both normal and disturbed children. These records were reviewed and discussed in the group meetings. The aides were also taught to administer the screening instrument and were asked to rate the children, using this protocol.

After this initial period, the personnel were assigned to treatments and worked at the various Head Start sites four morning a week. On the fifth day, usually Friday, a weekly meeting under the guidance of the two trained therapists was scheduled. Discussions concerned problems which had arisen during the week, either in the behavior of the children, the needs of the aides, or the classroom teachers. At these meetings role-playing and other techniques were employed to get at the aide's own feeling about the children. The psychologist of the Delegate Agency met with the group once a month and served as liaison between project and agency personnel. In addition, there were occasional trips to Centers such as the Mt. Sinai Therapeutic Preschool, the University of Southern California Speech and Hearing Center, the Engineered Classroom for Educationally Handicapped Children, directed by Dr. Frank Hewett, and other institutions dealing with similarly handicapped children. These visits together with the regular weekly sessions helped the aides to develop increased awareness of the needs of the children with whom they worked.

APPENDIX B

GUIDELINES FOR INTERVENTION WITH PROBLEM CHILDREN[1]

These guidelines have been prepared for the use of caretakers of young children, including preschool teachers, assistant or aides, parents, and other professional or paraprofessional personnel who have not been trained to work with emotionally disturbed children. They present a systematic procedure for encouraging the establishment of productive and positive behaviors, whether at home or in the classroom, so as to achieve the full potential of each individual child. In applying each of the suggestions, the central focus must always be on observing and studying the individual child and then prescribing an appropriate program of education and remediation.

1. Observe each child's behavior so as to (a) pinpoint when a particular behavior occurs, (b) what the child does, and (c) what happens to him as a consequence of this action.

Example: (a) It is story time and the teacher has asked the children to sit in a circle around her. The teacher ignores Johnny, who continues to wander about even after she has begun reading. After a while he sits down at the periphery of the circle where he wiggles about, gradually coming closer to a boy who is particularly attentive to the story. When the teacher stops reading and shows the illustration to the children in the circle (b) Johnny surreptitiously pinches the boy next to him, who lets out a loud squeal. (c) The teacher asks Johnny to come sit next to her and puts her arm around him (ostensibly to restrain him) while she continues reading. Johnny gets to look at the pictures in the book as the teacher reads.

Analysis: In this example it can be seen that the situation itself is set up so that Johnny can only get the attention he needs by some inappropriate action. When the inevitable occurs and Johnny misbehaves, the consequence, as perceived by Johnny, is that he gets to sit next to the teacher, look at the pictures as the teacher reads, and is hugged and given the comfort he wants. Obviously, these consequences will only serve to increase the presentation of similar undesirable behaviors.

2. After observation, list the appropriate and inappropriate behaviors, with the situations in which they have occurred and the consequences as perceived by the child. In the above example, the list might be as follows:

Appropriate	Inappropriate	Perceived Consequences
Sitting quietly	Pinching peers	Sitting next to teacher
Listening to story	Disturbing lesson	Physical contact
Following instructions	Disregarding instructions	Looking at pictures

[1] Used in the six-week training program at the UCLA-ECRC.

3. Observe the child carefully to see what types of consequences he values; for instance, verbal praise, smiles, or physical contact may be desired by some children whereas others may prefer food, a toy, or permission to engage in a particular activity.

4. At first, behavior which only approaches the desired goal should be rewarded; later, demands can be increased and higher levels of performance required before providing the reward.

5. In the initial phase, reward the desired behavior whenever it occurs; later rewards should be presented less frequently.

6. Appropriate behavior must be rewarded immediately so that the consequence will be closely tied to the specific action.

7. When inappropriate behavior occurs, either presentation of an unpleasant consequence (e.g. isolation from the group) or deprivation of a desired consequence (e.g. a privilege or reward) may be used. Again, the consequence must be meaningful to the particular child.

8. Try to avoid setting up situations which are known to produce inappropriate behavior; if a situation begins to develop, intervene to divert or lessen the child's commitment to an undesirable course of action.

9. When trying to eliminate unacceptable behavior, provide the child with alternatives for which he may be rewarded. Specify clearly what these desirable behaviors are and set up contracts or agreements so that the child will understand the relationship between his acts and their consequences.

10. Use the minimal consequence which will achieve the desired behavior. This is particularly true in the selection of punishments: removal from the group may be unnecessary if a stern look will serve.

11. Be consistent in the application of rewards and punishments. In reducing the frequency of rewards for learned behavior, be sure the child appreciates his achievement and can provide his own rewards.

12. Try to obtain increased consistency by informing the other adults involved with the child the procedures which are being used. Providing a copy of these guidelines may be of help.

13. Do not be discouraged if the child doesn't change as rapidly as anticipated, or if he suddenly displays again the undesirable behaviors which were thought to have been eliminated. Try to find out what real life problems are present in the child's environment which may be blocking progress.

14. Patience, humor, and flexibility are essential ingredients of a successful program with emotionally disturbed children.

APPENDIX C

THE CEDARS-SINAI TRAINING PROGRAM FOR THERAPEUTIC NURSERY SCHOOL TEACHERS[1]

The training program is supported by an NIMH Grant #2T41 MH 10547-02 and carries with it a stipend of $1,000 a year, payable in two parts. Eligibility requirements are: (1) a B.A. in any field, and (2) one year's experience working with normal preschool children. In affiliation with Pacific Oaks College, the work of the training year fulfills 16 units toward a 30 unit Master's Desgree in Human Development for those applicants who are interested.

The program begins in September and ends in June. For four days a week, the daily schedule is from 8:30-3:00, and includes three-and-a-half hours of practicum and two hours of classes. The fifth day of each week is in the field. The practicum involves work with individual children and groups of disturbed preschool children, under the supervision of educational therapists.

The afternoon classes are the following:

1. Therapeutic Techniques with Disturbed Children.
2. Family Interaction and Psychodynamics.
3. Clinical Aspects of Child Development.
4. Weekly Staff Meetings.
5. Family Interaction Laboratory.

The students learn to make developmental assessments and to present case material. They work with a wide range of emotional problems and are well prepared to deal with young children in a variety of settings. They also learn interviewing techniques with parents and to conduct educational group meetings.

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[1]This training had been completed by the Study Supervisor as well as the therapist who worked with one of the treatment groups.

APPENDIX D

Kohn Problem Checklist and Competence Scale

Instrument and Manual

APPENDIX E

Observation of Curricular Input (OSCI)

APPENDIX F

Anecdotal Records

THERAPIST: ILA BROWN

CHILD: A.M. (I.D.# 105011)

A.M. was the second youngest of 12 children. Her father was dead, her mother on welfare. Some of her older siblings had had difficulties with the law and one older brother was in prison. A.'s mother felt abandoned and powerless to effect a constructive change in herself or her situation and seemed overwhelmed by the demands and pressures of her life.

Although of average height and well-built, A. had a number of physical problems which had to be dealt with before her psychological problems could be handled. Her medical history showed anemia, a recurring scalp infection, gross visual defect including near-sightedness and strabismus, and a possible hearing impairment.

When first observed A. had a down-cast expression and her eyes did not seem to focus. Often she used her hands to obtain information usually obtained by sight; for example, working on a puzzle, her hands would first feel the edges and size of a puzzle piece, then feel the size of the openings in the puzzle, and then try to place the piece. Her movements were uncoordinated and jerky and she walked with her ankles turned in.

A. was unresponsive to her environment, spoke very little, and did not involve herself with her peers, although she did occasionally engage in parallel play. She seemed to be in touch with reality but had difficulty handling problems that arose. For instance, A. attempted to ride a pedal-driven child's car which refused to move. She got out, looked under it, and then tried to lift it by the steering wheel, which came off in her hands. She worked frantically at putting it back on, and finally succeeded. She then pushed the car to the sidewalk area and got in again, but still the car would not move forward. A. tried to make it go by just pushing against the ground with her feet, and was obviously frustrated. However, when the assistant teacher approached and asked if she wanted help, A. jumped out of the car and ran away.

During the course of the therapy A. did receive corrective glasses. When she wore them, her relationships with peers improved tremendously. However, she frequently failed to wear them; either they were left at home, had been broken, or they were at school but no one had remembered to give them to her. Accordingly, her progress vacillated tremendously. When she did not have her glasses, she withdrew into her own silent world. When she wore old glasses with insufficient correction, she participated minimally. With the help of her new glasses, she was able to respond well both physically and verbally.

Following are a few brief episodes which present the course of A.'s progress:

Session #1. For the first part of the morning, A. played alone or only in a parallel fashion, near peers. Her affect was downcast, chin on chest. She was not wearing her glasses. Though verbalization was going on all around her, A. was not included nor did she attempt to enter the conversation. The therapist sat on the floor next to A. When one of the other children pulled a toy away from her, A. made no response. The therapist stopped the other child and told her she needed to ask A. if she wanted to share her toys. She did so and A. gave her the toy without speaking. Another child who came along and wanted one of the toys was also told to ask A. for it; he did and A. gave it to him with a smile. As the boy stayed and played with A. for about 15 minutes, she seemed to relax. When the boy said, "I like trains," A. repeated the statement clearly but in an emotionless voice.

Session #2. Since A. had great difficulty in entering new situations alone, part of the therapist's procedure for establishing trust was to be physically near and emotionally supportive. In the second session, A. was wearing her glasses. A boy was acting the role of a monster, with appropriate sounds, growls, and scary noises as the other children ran squealing in mock terror, A. watched from a distance with a slight smile. The thereapist took her hand and walked closer. After standing and watching for a while, with A. continuing to smile, the therapist stepped forward, still holding A.'s hand, and A. went along without pulling back; the therapist asked A. what she thought of the scary monster. A. responded, "Funny." However, she refused to join the other children in the game without the therapist. Within the boundaries of where the other children were playing, the therapist released A.'s hand and told her to joint the others. Looking very uncertain, she went over for a few minutes as the therapist stayed and watched. A. returned to the therapist and remained close for the rest of the session.

Session #5. A.'s progress toward accepting herself was slow. During the fifth session she was wearing her new glasses and holding a doll. The therapist who had been given a compact by one of the other children, looked at herself in the mirror and said, "I'm pretty; I like myself!" She then put the mirror in front of A.'s face, and asked her whom she saw in the mirror. A. said, "doll." The therapist took A. to a large dressing table mirror and asked her to tell whom she saw. Again she looked in the mirror and said, "doll." Finally the therapist asked if she saw A. in the mirror. A. responded, "No, just doll." She refused to see herself.

Session #19. It was a long time before A. reached the point of being able to express her negative feelings about herself. On this occasion A. was playing by herself when the therapist arrived. She was led, resistingly, to a table where four children were working with clay. A. took a lump of clay and pounded it with great intensity for about 15 minutes. Toward the end of clay time, the therapist made a little stick figure. A. labeled it "boy" and smashed it. A second figure was labeled "Mama" and again smashed. A third figure, smaller

than the other two, was also called "boy" and smashed The therapist made a reasonable likeness of A. and asked who it was, but received no response. Her peers at the table yelled, "A.!" Again A. was asked who it was, but she refused to respond. However, when the therapist told her it was A. she said, "Me! I want it." She took the clay figure and smashed it, saying, "I don't like her. Bad " and walked away from the table.

Session #20. The therapist gave A. a picture of a clown, which A. reversed so that the turned-down mouth seemed to be smiling. She scribbled all over the clown's face, except the mouth. Her only verbalization was when she traced over the mouth and said, "Happy mouth." The therapist talked about A.'s mouth and drew a picture of A. with a "happy mouth." This time A. did not scribble over it but smiled broadly.

Session #22. A. ran over to the therapist and hugged her when she entered the classroom. A. was wearing her new glasses. For the first time she offered to read the therapist a story, identifying and labeling objects in pictures with animated facial and vocal expression. She then joined six peers in a dramatic play situation and evolved into the leader, a role she sustained for a short time. When the class engaged in a puppet-making activity, A. joined the group and made a "monster," which she proceeded to bang on the table until it became disruptive to the other children. She was removed from the immediate area and placed in a clear space with a small-sized metal chair which she was given permission to bang. She did so with vehemence, joining the therapist in vocalizing such sounds as "boom! bang pow " After a short while she dropped the chair and picked up a large, stuffed animal. A. beat it over and over, kicked it, jumped on the stomach, and ground her feet into the face. Finally she kicked it out of the area entirely. She went to the doll crib, got a doll, and repeated the same procedure. After kicking it into the dramatic play corner,she very violently kicked it into a cupboard and slammed the door. Then she ran to the therapist and said she needed to go to the bathroom. She locked the stall door muttering incoherently. The therapist tried to reassure her by verbalizing her feelings of anger and fear. A. yelled, "I'm going to hit you!" Finally, she unlocked the bathroom door and came out. As she was washing up, she said, "I not mad at you anymore " She then ran outside to join the other children in a running game, sharing equipment and waiting her turn.

Session #27. Near the end of the therapy period, A. was able to play constructively with peers, initiate conversations with both peers and adults, and begin to assume responsibility for taking care of her own glasses. A. was very involved with her peers, carrying on conversations and sharing equipment, even though she was wearing her old glasses. The therapist learned that A.'s new glasses had been in the school cupboard all week but no one had bothered to give them to her. The therapist taught A. how and where to get them, put them on and take care of them on her own. The teacher was told that A. would be taking responsibility for getting her glasses and she agreed to help.

Session #30. This was the last session. A. had been completely self-sufficient and responsible for the care of her glasses for the last few meetings. She seemed to have improved considerably, but when the time for final farewells came, she refused to accept this as the last visit and said, "See you Monday." A. had profited considerably but needed more help.

CHILD: W.M. (I.D.# 10701)

W.M., a well-built child, was the third youngest of 11 children. During the first three years of her life she had been kept almost continuously in a crib and had suffered such severe deprivation and maltreatment that she was taken away from her parents and placed in a foster home. Her foster parents had three of their own children, all older than W., and another foster child, a boy approximately the same age as W. who was in the same Head Start class. At the beginning of the therapy W. had been living with her foster family for about a year and was just learning to walk steadily, had minimal language, was not completely toilet-trained, and displayed very poor motor control. Her gait was awkward and she ran stiff-legged, with toes turned in and arms moving erratically at her sides. She was fearful and apprehensive and unable to relate to either peers or adults.

Because of the deprivation W. had suffered, it was necessary for her to experience a more satisfying babyhood. After trust had been established, the therapist brought a nursing bottle for W. to use whenever she wanted to. W. did not hesitate; she role-played a baby enjoyably for many sessions. She knew she could use the bottle during moments of stress, after which she seemed to be able to relate on a four-year-old level. Her need to be like a baby was worked out in dramatic play with peers. For instance, she would lie in the large doll crib, sucking the nursing bottle as she smiled with half-closed eyes and made baby-like sounds. When asked, "Are you a baby?" she answered, "Baby. Baby. Me baby."

During the course of the treatment and concurrent with giving her complete freedom to play a baby role, the therapist began to point out the inadequacies of a baby compared to a four-year-old, giving strong positive reinforcement for age-appropriate behavior. The pride of performing on a more mature level was shown when she engaged in water play, turning on and off faucets, applying soap, and drying her hands. She verbalized her satisfaction with her own competence as she remarked: "I four-year-old. I can do it."

Continuing to build pride through mastery, W. was taught to defend her rights in relationship to her peers. She also became willing to attempt difficult tasks, such as riding the tricycle, even though she first met with frustration. When, after many fruitless attempts, she managed to turn the pedals for four complete revolutions, she proclaimed proudly: "I four-year-old girl. I big. I can do it."

At lunch, after this success, she did not limit her conversation to her foster brother but talked freely with peers.

By establishing trust and using positive reinforcement W. was able to begin building mastery as she worked through the baby stage. Proceeding through the various developmental tasks, she first became responsible for her own toileting, then for putting on and taking off her clothes (shoes, sweater, jackets), manipulating small objects, becoming able to measure spatial relationships, and developing large muscle skills.

Progress continued slowly and there were occasional set-backs. A particularly severe problem was W.'s confusion as to who really was her mother. She would stop strange ladies in the supermarket, or visitors to the classroom, and ask, "Are you my mommy?" Her concept of "mommy" was sometimes a frightening one, in which case she became one of the "monsters" of W.'s frequent fantasies. W. spoke often of these "monsters" whom she drew in many shapes and forms. At other times, however, the mother concept was a good one, and this was somehow identified with "Indian." As therapy progressed, W.'s pictures of monsters and Indians began to merge. At the end of the therapy program, which consisted of 33 visits, W. was functioning as a competent four-year old. Just before the school closed for the summer, W. was transferred to another foster family in another city, where there were no Head Start sites or nursery schools. All attempts to obtain some continuity for W. were unsuccessful.

CHILD: T.T. (I.D.# 103042)

T.T. had been randomly assigned to the control group. However, she had been creating so many problems in the classroom that the teacher insisted upon having help. The therapist who had been working with another child in the same class spent one session with her after her assigned child had been terminated. This proved to be an untenable situation because of the continued presence of the first child and a therapist from a different site was assigned to T.

T. lived with her mother, step-father, and two younger siblings. At the time therapy was begun Mrs. T. was expecting another child. Very little was known of the home environment except what could be inferred from the fact that T. frequently showed the marks of severe beatings on her face and body. She also displayed detailed knowledge of the sex act, often imitating this behavior in her dramatic play. After the second visit the family moved in with the grandmother and no address or telephone number were reported. T. was absent over long periods of time and there was no way of reaching her.

T. was a compactly-built, well-dressed child. She was hyper-active and hit other children, frequently without provocation. She did not verbalize easily, and most of her interactions with both peers and adults were on an aggressively physical level. She was sullen and rebellious, and had a very short attention span. According to the Head Teacher, T. displayed great jealousy toward any and all younger children and, in

dramatic play, usually assumed the role of baby. A great part of the initial sessions consisted in establishing trust. The therapist found a nursing bottle to be a good tool, permitting T. to relax and feel accepted.

Session #4. At the beginning of the day T. was seated with peers but not involved with them. The therapist took her aside and gave her the nursing bottle, telling her that it was all right to "be like a baby" with her. She accepted the suggestion readily; sitting on the therapist's lap, she leaned back, closed her eyes, and sucked steadily on the bottle. The subject of babies was discussed and T. commented that her daddy "killed the baby." Her tone indicated that she felt this was a good thing. When asked whether her daddy's killing the baby made her happy, she nodded her head vigorously in assent. The therapist verbalized the child's feeling that her mommy never had enough time for her because she was busy with her baby brother and sister and that the lack of attention made her mad at them and her mother. She agreed emphatically both physically and verbally. When she was told that the therapist was her special friend and would give her all her time, she smiled broadly. Thereafter, whenever any other child approached she emitted a baby-like howl of displeasure. She had to be constantly reminded that even though the therapist spoke to other children she was at the school especially for her.

Session #5. T. spent most of the day testing the affection of the therapist. When it was time for snack, she ran to the rug room and locked the door from the inside. When requested to open the door she laughed gleefully, and did a great deal of banging and running about. Only after the therapist told her she couldn't be her special friend if she didn't come out did she finally unlock the door. At lunch time, she threw her dishes and utensils across the room. After walking T. over and making her clean up, the therapist stopped to speak to another child. T. began a baby-like howl and ran to the locked bathroom door, kicking and pounding on it. She was restrained and told that when she was mad she could talk about her feelings. She stopped the banging, crawled onto the therapist's lap and stayed there until it was time to go home.

Session #6. T. sought attention in devious ways, by throwing things, disobeying site rules, berating peers, etc. In each instance, limits were set and maintained. At the beginning of the day, she was held, rocked, and allowed to suck her thumb and cuddle while talking about how nice it felt to be like a baby. Later, during lunch, she pushed away her food, knocked over her chair and said, "Not enough baby time." She was praised for verbalizing her feelings. She then went over and asked a peer for materials before she grabbed them. Again she was praised for asking. The next time she asked and waited and did not grab. For the rest of the morning, she was able to interact appropriately with peers.

Although considerable progress had been made over the six sessions, this child obviously needed more help.

THERAPIST: HATTIE BROWN

CHILD: B.C. (I.D. #103061)

B.C. was a large child for her age. It was difficult to understand her, and she often lashed out in frustration when she failed to make her needs known. She seemed to have a cold most of the time, adding to her speech problem. She played alone most of the time, usually with a somber or downcast expression. B. was unable to relate to peers and did not know how to play with them. She was destructive and injured children or adults in fits of anger. She demanded an excessive amount of mothering; when this need was not met the child would break into silent tears or engage in aggressive behavior. A frequent tactic was to lock herself in a room and refuse to come out. Her tantrums upset the class so that she would often be sent home.

B.'s feeling of being unwanted, unloved, and unattractive were rooted in reality. B.'s mother had disappeared, leaving her and a younger sibling with the grandmother, who had 13 children of her own to raise. There was a strong resemblance between the therapist and the child's mother, which may have caused problems in building up a good rapport. She was afraid to invest too much affection in the therapist who might disappear just as her mother had. Unfortunately, this fear also became a reality.

On the first visit, the therapist arrived after B. had locked herself in a small room used for equipment storage. The teacher told the therapist that B. had tried to get her attention but she had been busy with several other children. Thereupon B. went to a table on which there were some books and proceeded to rip them apart. When the teacher reprimanded her, she had run to the room and locked the door. After some time ensued during which she refused to come out, the child's grandmother had been called. A little while later the grandmother came and took B. home. There was no opportunity to work with the child or the grandparent at this time.

Session #1. B. came to school with a downcast expression. She was quiet and when the assistant teacher asked how she was she hesitated, sat on a chair before replying, and said, "I no seel good." The assistant then engaged her in activity with the wooden puzzles and B. put one after another together with the assistant picking up a piece, giving it to B. and B. putting it in the appropriate place. After about 10 minutes the puzzles were completed and B. turned to a mosaic game, making a design of the red and yellow triangles and squares. The therapist sat down next to B. Every once in a while she would look at this new person, put her hand in her lap, and return to the mosaic game. She did not speak at all. When time came for lunch the therapist offered to help put the pieces back into the basket, making a game of the task; as she picked up a yellow square, she said, "I have a yellow one." B. also picked up a yellow square and repeated, "I have a shello one." The therapist smiled and said,

"You have a yellow one." B. made no response but picked up a red one and said, "I have a red one." This continued until all the pieces were picked up. Then B. said, "We can play more after lunch." B. went to the doll area, took a sponge, wet it, and went to the mirror, and began to wash it. After the teacher had announced game time in the rug room, B. remained in the doll corner until the teacher had gone into the other room. During game time, B. continued to stare at the therapist from time to time. Before lunch, the grandmother arrived to take B. home but the teacher told her that B. had looked forward to having lunch with the class and would be disappointed if she had to leave. At first the grandmother refused, but then she agreed to wait. While the children had lunch the therapist spoke with the grandmother, who talked about the problems she had had with B.'s mother, and now with her other children. B. ate lunch quietly and left with her grandmother.

In the subsequent three sessions, the therapist began to develop a relationship with B. mainly by paying attention only to her and not insisting that she join the group. She was allowed to select what she wanted to do within the limits of the class. The destructive behavior began to decrease. Unfortunately, at lunch time of the fourth session, it was casually mentioned that the therapist was B.'s special friend. This broke up all the trust which had been built up. B. became instantly quiet, got up and went over to the teacher's table. When the teacher tried to get her to go back to where the therapist sat, she said, "I want to be with you." The teacher tried to convince her that she was still B.'s teacher, and that B. also had a special friend, but B. started to cry, ran into the rug room, and would not be consoled. After this, the therapist could work with B. only indirectly, as one of the group. B. accepted this, watched the therapist with interest, asked for special songs or stories but would never go off with the therapist alone. This type of relationship continued for 13 more sessions and seemed to produce positive changes in B. who began to play with other children and seemed better able to accept herself. During this period B.'s mother returned for a while and B. was much happier. She talked a great deal about her mother and how they were now going to live together. However, the mother disappeared again and the therapist could not continue with B.

CHILD: B.D. (I.C. #108012)

B. D., a small boy with noticeable physical problems, had seven older siblings from different fathers. The children were being raised by a mother who continued to provide a series of temporary "fathers." There was one younger child who had never been seen by the teacher although she reported many home visits. The mother refused to visit the Head Start class. Several of the older children already had police records and even a child of 12 was reported to be a heavy drug user. The teacher suspected that the home was being used as a connection point for addicts in the area.

B. had very poor motor control, resulting in numerous accidents when riding various wheeled toys. He walked with his legs turned in and his

arms trembled; his eyes were slightly strabismic. B preferred to be with adults and was verbally fluent with them. His conversations, although carried on in a soft, quiet tone, were always about violence: cops that kill and shoot, etc. This verbal facility was notably lacking when he had to cope with his peers in any conflict situation, such as an argument over whose turn it was, or who could play with a certain toy; at such times he would either appeal to an adult for help or, if no adult were available, just give up and walk away. If struck by a peer, he made no attempt to defend himself or strike back, but would attempt to seek protection or redress from an authority figure. His favorite activity, in which he engaged about 80% of his time in school, was to take over the outdoor playhouse and remain there by himself.

Session #1. After establishing contact with B. the therapist tried to involve him in activities which would require him to talk to his peers. For instance, at snack time B. mentioned that he had a dog. Another child chimed in that he also had a dog. B. was asked if he knew the name of the other child's dog. This developed into a game in which B. asked all the children their names. Before the morning was over, B. came back to the therapist and reported with a big smile: "I know all the names and you don't!" He proved this by naming several of the children. At lunch, he spoke only with the therapist, although he did try to get the child next to him to tell him her name, but without success.

Session #3. B. was playing with a doll and another child snatched it away. Instead of trying to get it back himself, he ran to the therapist for help. He was told that he would have to tell the child he wanted it. After considerable urging he went back with the therapist and asked for his toy. Fortunately, the child relinquished the toy without further argument.

Although there was time for only five sessions with B., the therapist felt that considerable progress had been made. B. had learned to defend himself and would no longer allow himself to be pushed around or forced to give up his turn or a toy with which he was playing. He also was able to relate more with his peers and appealed less frequently to adults for help.

CHILD: R.C. (I.D. #105031)

R. was the youngest of six children. His mother, a very quiet woman, claimed she didn't know what to do with R. There was no father present in the home and the older boys were constantly in trouble with the law.

R. was average in size for his age and appeared to be in good physical condition. He was mentally alert and had good verbal fluency. However, when first observed R. wore a tense closed expression and refused to take part in any class activities except block building. When the teacher tried to remove him from the block corner, he would kick and throw a temper tantrum. Peers were allowed to come into the area only with his permission, and they could build only what he wanted them to. He was quite willing to talk about the structures, but his stories usually concerned witches, burning, and killing. When he had finished a building, or when he decided

another child had been there long enough, he would kick the blocks apart viciously.

Over the course of 19 sessions with the therapist, R became willing to engage in a variety of activities, play with other children, and sit quietly during story time. The therapist felt that a great deal of progress had been made with this child.

CHILD: E.C. (I.D. #114012)

E. C. seemed to be physically and mentally average for his age. However, he was a very angry boy, hyperactive, destructive, hostile, and anxious. Little information about the family background was available to the therapist, who knew only that there was no father present in the home. Mrs. C. usually called for her child, but never greeted him. Her first action was to feel E.'s pants to see if he had wet himself; she would then tell him to go to the bathroom and he would silently comply. When his mother was present he was fearful and submissive, which was very different from his usual classroom behavior.

When first observed, E. was moving quickly from one thing to another, usually trying to hurt someone or destroy property. He would strike out or throw sand with no sign that he was aware of hurting anyone. He also seemed self-destructive, frequently putting himself in extremely dangerous situations. He would climb to the top of the slides or swings and jump into mid-air with his eyes closed. He would talk about trees and insects as being his friends, and give them names, play with them, build houses of sand for them, and look as if he were enjoying himself. Then he would suddenly kill the insect. At such moments he would go into a state of panic, thrash about, jump on tables, push things over, knock other children's things down or kick the children. He was avoided by most of the children because he hurt them. He was interested in stories and science projects but he found it hard to sit for any length of time. Meal time was an anxious time for him. Although he had an excellent appetite his bizarre actions at the table caused the teacher to isolate him during meals. When his mother arrived he became quiet and exhibited no trace of his previous behavior. He did not look at her, but walked at her side with his head bent down.

Session #1. E. came to school angry and started to throw things. The teacher stopped him. E. said he did not want to come to school. Outside he went to the sand box, played with his peers for a while, then suddenly took a handful of sand and slammed it into another child's face. When the teacher told E. he could not do that and stay in the sand box, he started throwing sand at the teacher; as she approached he ran to the other side of the sand box, laid down, then stood on his head in the sand, then began to roll in it. He got out of the sand box, climbed to the top of the swing, and without looking, jumped off, ran back to the slide, climbed to the top, stood there, ran down the slide, jumped on top of the table, ran up the slide and jumped off again; ran around and tried to push the slide through the bars of the jungle gym, climbed to the top of the bars, hung upside down and let go, landed on the ground, climbed on

the slide again, jumped off with arms outstretched. When the teacher asked him not to jump off the slide again, E. ran up the slide steps; the teacher tried to grab him, but he jumped from the slide to the table, then ran across the table and jumped without looking. He landed near the jungle bars, climbed to the top, stood looking, then turned upside down and fell to the ground; ran back to the slide, went up the front and jumped off the back; ran to the tire swing, got on, started to swing as fast as he could, pushing higher and higher; when the tire was very high he jumped off, eyes closed, landed on table, jumped off, and ran back to the tire. The teacher tried to talk to him, but he yelled, "I don't like you," and ran away to climb the bars again and again jumped off without looking. Snack time was called by the teacher but E. refused to go inside. He ran to the slide, pushed it over, ran to the table, got on, jumped from the table to the slide that he had pushed over, ran back to the bars with the teacher after him. E. ran to the tunnel, climbed on top, jumped toward bars, arms apart, not looking. Finally E. ran into the classroom. He refused snack, pushed the science display off one end of the table, talked to the teacher about ants and tried to let ants out. When he was not allowed to do this he ran to the books, sat down, then got up and ran outside. He refused to come back and repeated the manic behavior described above. Returning to the classroom, he pulled chairs down, tried to upset the science table, and asked the teacher to paint. She put an apron on him; he took the pink paint and made bold splashing strokes, looking very angry. He stopped abruptly, took the apron off and ran to the fence. He picked up a toy kitchen pot and started to bang it against the fence, then threw the pot down, ran to the tire swing, climbed on it and began to swing and kick at other children. The teacher came over and began pushing him and he stayed for a while. Returning to the classroom, he asked the teacher to read a story about ants and he sat for almost 15 minutes while she talked and read to him. During group singing, he sat with his head against the teacher's leg, and although he did not sing, he did participate in the finger games. As the teacher sat with her arms around him he rocked back and forth. At lunch he found his place, picked up his fork and put it into the milk, then started stabbing the table with the fork. He took the fork and stabbed himself in the stomach. He took hands full of food, mashed it on the table, poured milk over it, and then ate it.

When his mother called for him, she asked, "Were you a good boy today?" E. replied that he didn't know. His mother then asked if he had broken anything that day. E. shook his shoulders and replied in the negative. He then turned and ran outside. When he came back he had wet his pants. Mrs. C. asked with a smile, pointing to the wet pants, "Why did you do that? You make me so ashamed! You know how to go to the toilet! There's one right outside. Why didn't you go? I'm ashamed of you! You know what's going to happen? You will go home and go to bed. Why did you wet your pants? Are you going to do that again? Oh, I know you will! Big boys don't wet their pants!" When E. turned away from her tirade, Mrs. C. grabbed his face and turned it toward her, saying, "Look at me! I'm talking to you!" Still with a smile she turned to the therapist and said, "He knows a lot of things. I teach him to appreciate nature; maybe that sounds silly to you but I want him to appreciate all the little things in nature that God gave us." She turned back to E. and said, "God won't like what you did!" Then, continued speaking to the therapist, "He likes the trees and he has given the trees near our house names. One he calls friend Tommy and one friend John. All the trees are his

friends. I love nature and want him to love it too." E. came back with a caterpillar, which he showed to his mother. "I'm going to put him into a cage." His mother replied, "No you don't put it into a cage! It won't be free. Would you like to be in a cage?" When E. replied that he would, his mother said, "You won't be able to run around free." E. seemed to have lost interest in this conversation and changed the subject abruptly.

There were only five therapy sessions with E. By the fifth session E. had stopped wetting his pants in class, and was able to go to the bathroom alone and return without help. Some of the children were beginning to seek him out and he had made friends with several boys and shared his insects with them. He still needed considerable help, but he dropped out of Head Start and no further contact was possible.

THERAPIST: BEATRICE SANDLER

CHILD: R.A. (I.D. #109011)

R. A. at four and one-half years was as tall and large as a nine-year-old boy. His physical coordination was poor and his hands were unsteady with small objects. When emotionally upset his whole body trembled. R. related poorly to peers and adults. During activities in which the whole class was involved, he would appear preoccupied and retreat into his own world. At such times he seemed dazed or bewildered and would, on occasion, fall asleep. At other times he pushed, shoved, and hit his peers, and would try to grab toys out of their hands. To avoid taking responsibility for clean-up in the classroom, or to avoid doing anything he didn't want to do, R. pretended to be either sleepy or sad. When criticized by the teacher, he would sulk, cry, or throw himself on the floor in a tantrum. He also was inclined to tell wildly exaggerated stories.

Mr. and Mrs. A. were divorced and R had never seen his father. Mr. A. did not support the family. There was a nine-year-old brother who was also large for his age and had many emotional problems in school and at home. Mrs. A. was on welfare. She was pleased with the extra assistance her child was receiving in the Head Start classroom, and was more than willing to cooperate with the teachers and therapist.

The program of therapy was designed to satisfy R.'s excessive need for sympathy and support, with the expectation that he would then be able to perform at a more mature level. The following episode illustrates the procedures used:

Session #11. Since R. had been unable to participate in group singing or story-telling, he was taken outside while the rest of the class was engaging in this activity. He jabbed the punching bag for a while and then asked to go on the swing. R. swung by himself for about 30 seconds and suddenly jerked his body, fell off the swing, and lay full length in the dirt, face down, with the swing moving wildly above him. The therapist helped him up, hugged and comforted him. He seemed to cheer up and rode a bike for a little while and then went in for a snack. When the children were being given the hearing tests he was able to help two peers who were afraid to go. With compassion he took their hands and walked with them to the testing room. At free play time he played cooperatively with two other boys.

Session #21. A great deal of effort had been expended on getting R. to behave appropriately so that he could participate in group activities. During this session he was permitted to sit with the story group. At first he was disruptive. He grabbed a girl's rug and refused to return it, telling the therapist, "I'm stronger than you!" After some discussion the rug was returned and R. was able to join in group singing.

Over a period of about four months there seemed to be an improvement in his general physical coordination. The changes that took place in R.

in the Head Start classroom had its good effects at home; Mrs. A. was pleased with the progress that R. was making and often consulted the teacher and therapist so that she could learn to help her son over some rough spots and improve her relationship with him. Both R. and his mother tried to be more positive, the home atmosphere improved, with consequent benefit to the entire family. Having had such a positive experience with R., Mrs. A. became more aware of her older son's problems and was able to seek psychological aid for him.

CHILD: J.M. (I.D. #101021)

J. M., an aggressive, angry boy, was unable to verbalize his feelings. He was constantly acting out and evoking reactions in adults, which produced feelings of guilt and increased his anxiety. One major fear was that he might be separated from the group. J. did not initiate play with peers or talk to classmates. He would take things he wanted without asking permission. He would push, shove, and hit others, and generally tried to prevent them from completing their activities. While seeming to comply with adult requests, he would never actually do what he was told. He was uncooperative and refused to abide by normal rules and regulations. Although his more common modes of relating to teachers demonstrated hostility by kicking, biting, etc., he sometimes attempted to obtain physical contact by leaning against the teacher or getting on her lap. He was rarely seen smiling or interacting with his peers. He was often preoccupied and lost in a world of his own to the point of being unresponsive to things or to people. Sometimes he appeared bewildered or confused. He was restless, unable to sit still, and often put toys and beads into his mouth.

J.'s father was born in Mexico and had been in this country for a number of years. However, he was unable to speak English, had found it very difficult to adjust to this country, and worked only infrequently as a dishwasher. From time to time, he left his family to return to Mexico for several months. The last time he was away he was gone for five months. J.'s mother, American born of Mexican parents, was a high school graduate. There were just two boys in the family, J. and a brother who was one year older. In order to support the family, the mother had a job as an unskilled factory worker. The one visit to the home revealed that J. was in control, with his mother constantly begging and pleading with J. to behave, or "please, be good." As a last resort she threatened that if he didn't behave, "papa will hit you." However, J only modified his behavior when she went to the door of the bedroom where the father was sleeping and called, "Jose, Jose, come out!" It wasn't possible to talk to the father but the mother was very anxious to help all she could so that her child "would be a good boy and be able to go to school."

J. was very hard to reach. It took many weeks of consistent support for him to feel free enough to verbalize his feelings and transfer his aggresssions from people to objects. Within a month of the time therapy was initiated, J. was able to feel enough trust in the therapist to communicate in complete sentences and much more clearly than before. He was also having conversations with his peers and relating to them in dramatic play situations. About two months after the start of treatment, J began to be

willing to share. He also became able to accept that there were limits, for his classmates as well as himself.

J.'s behavior over the period of treatment followed a pattern of alternating progress and regression. Examination of the daily anecdotal notes indicates that a qualitative change began to take place just after Christmas vacation. This trend continued for about three weeks and then there was a series of short regressions and gains until the 29th session, when Mr. M. returned to Mexico. Although substantial improvement had been made, as manifested in terms of increased interaction with peers and adults, ability to participate in classroom activities, ability to focus, and the development of a calmer, happier feeling, comparatively little progress was made in the 10 sessions after his father left.

CHILD: E.P. (I.D. #105102)

E. P. and his identical twin were tied to their cribs by their mother until about the age of two-and-one-half years. Their parents were divorced and E.'s father took both boys and an older girl to live with him, his new wife, and her three children. E.'s natural mother had neglected the children and probably also abused him and his brother. As a result, E.'s physical and emotional development were not at a level appropriate for his chronological age. His tremendous need for love and approval interfered with his ability to engage in normal classroom activities. E. found it difficult to participate in a group or to settle for any length of time on an individual activity during the free-play period. He did not initiate play with peers.

Part of the treatment was to allow E. to regress as much as necessary to provide some of the nurturing he had missed. Water-play proved to be a good method, permitting him to relax while he was given the support he needed. The basin in the rest room was filled with warm, soapy water and E. enjoyed playing in the water and washing the toy dishes. A nursing bottle filled with either milk, juice, or water was kept available and E. would interrupt himself every few minutes, ask to get on the therapist's lap and drink from the bottle. This kind of play seemed to bring about a reduction in anxiety and made it possible for him to concentrate and particpate in group activity when he returned to the classroom.

At the outset of treatment, E. had been engaging in an excessive amount of spitting. An extract from the anecdotal records demonstrates the therapist's procedures in handling this behavior:

Session #1. E. was outside riding a trike. As he passed he would start to spit but at the same time he made a slight noise with his mouth. The therapist said, "Are you making a sound like a motor? I think you are a car." Each time he passed he would spit less and less and make more of a "brrrr" sound with his mouth and each time the therapist would do the same thing. He then started to pretend that he was a helicopter. The spitting stopped in the course of this activity and he continued to play that he was a helicopter.

Session #9. E. would put so much food in his mouth at lunch that it was difficult for him to chew or swallow. During this session, after snack, E. asked to play in the water. There were the usual toys, but this time there was juice in the nursing bottle. Most of E.'s water play consisted of taking water into his mouth and forcefully spitting it out, with a splash, into the basin full of water. While doing this, he laughed and looked anxious at the same time. When he was not reprimanded for this behavior he stopped and sat on the therapist's lap in a reclining position, drinking all the juice in the bottle, which had been two-thirds full. While holding him the therapist talked about eating snack and lunch. E. was told that he could always get seconds and there would be plenty of food, so he could take small bites. Practice in eating was played out, using plates and spoons. E. pretended to take food on an imaginary spoon and chew it. Then he said, "I take small bites." He was praised and reassured that he could get as much food as he wanted. Later at lunch he was able to eat without stuffing his mouth. Instead of wiping his hands on his shirt and pants he used a napkin and proudly reported: "I eat like a four-year-old boy."

In the course of the 16 visits, E. was able to establish a trusting relationship with the therapist. He learned to talk about his feelings and very clearly expressed his likes and dislikes. "Using words" was an important part of his development. The therapist was able to discuss with E. pertinent questions that related specifically to E., or to E. as he related to others, and E. learned to listen and react appropriately. One of the direct results of the trust established was E.'s ability to modify his eating habits. With constant support and the assurance that there was enough food, he became relaxed enough to eat less compulsively. The 16 visits were barely a beginning and E. clearly needed more treatment, especially in light of the seriousness of his problems. However, it was felt that the treatment sessions were able to modify a number of specific behaviors and lay the groundwork for continuing therapeutic experiences.

CHILD: C.E. (I.D. #106012)

C. E. was the son of a Mexican-American mother and an Anglo father; his parents were divorced. There were two younger siblings and Mrs. E. was pregnant again. The family lived with the grandmother and all were on public welfare. The mother never came to the Head Start site and there was very limited information about the family.

When first observed, C. had minimal speech, was unable to sustain prolonged interest, and exhibited many other signs of emotional disturbance. For instance, despite the fact that he was strong and well-built, with good physical development, he was unable to drive wheeled vehicles with the same ease and speed as his peers. He was withdrawn, either frowning with a worried expression or staring impassively into space, but in either case unresponsive to things or people. When C. did talk he made unintelligible growling and gutteral sounds, although he was capable of talking and communicating his needs. Sometimes he hummed

monotonously as he wandered about. He always insisted on sitting near an open door at craft or mealtime.

C. was unwilling to play with his classmates and was ignored by them. Sometimes he stood and watched the others play, but when asked to join them, silently refused. He was unable to participate in structured group activities and would restlessly wander off, touching toys until restrained by an adult. . He seemed to exhibit a compulsiveness in his manipulation of small toys and blocks; these had to be arranged in a certain order before he would play with them. Every day at lunch time he would point to the clock and say in a loud, strained, and husky voice, "Look at the cwock! Missa Smith gonna come. Time to go home."

C. responded very slowly to therapy. As part of the treatment he was encouraged to play with the family dolls. It was a month before he was able to work out some of his feelings with these figures. He strained, grunted, and growled as he had the dolls fighting each other. He wanted the baby doll in the father's arms. Once he put the father doll in the coiled wire of a telephone that was hanging over the side of a cabinet in front of him and left it there for most of the morning.

At the end of three months C. began to show signs of improvement. He seemed more relaxed and no longer frowned as frequently. Although he was still unable to share, he no longer chased other children away from him. His play was still primarily parallel but he showed more awareness of the children playing next to him. His voice became less gutteral, but his speech continued strained and husky. However, he would still stare out the window and retreat into his own world refusing to speak or respond when spoken to.

Obviously the 18 visits with C. were inadequate to make a real change in his behavior.

THERAPIST: NOLA SCHMIDT

CHILD: L.R. (I.D. #111011)

L. R., the third child and only girl in a family of four children, was a pretty strawberry blond with lively green eyes. She often had an impish grin, especially when she was angry. Her movements were agile and coordinated and she seemed to be in good physical condition. She was mentally alert, very quick in her movements, and competent in handling materials. In spite of all these apparent capabilities, she had inordinate need for the undivided attention of the adults with whom she came into contact.

At the beginning of this study, L.'s hostile aggressiveness had become a severe problem in the classroom. She attacked and teased children covertly and openly, especially those who had received any recent attention from the teacher. However, she could neither ask for nor accept the same personal attention when it was directed to her. For instance, she would always pull away quickly from any physical contact, even a hug.

Although there were many cues to indicate that she really wanted to go to the playroom, she at first refused the invitation. It was necessary for the teacher to bring her and stay for a few minutes of the session. Even then, however, she consistently avoided physical contact with the therapist. Toward the end of the study period, she was more able to accept what she wanted when it was offered, but she could still not make a direct request herself. As trust in the therapist was established over the course of the year, L. began to decrease her manipulative behavior. She could stay with an activity longer and seemed to gain more satisfaction through her own achievements. In the regular classroom she became helpful and cooperative and her aggressiveness toward peers noticeably diminished.

Well past the mid-point of L.'s visits to the playroom, a dramatic breakthrough occurred. Mrs. R. had found her daughter's therapy hard to accept, and was overtly resistent. Finally, she demanded a visit from both the therapist and the teacher. At this meeting, she poured out her grievances, which ultimately came down to the fact that L. was beginning to be accepted at school. As she felt unable to accept L. herself, she found outside tolerance undermining to her system of control.

As Mrs. R. talked about her daughter's early years she related her own experiences of rejection by her mother when she had been L.'s age. As the teacher and the therapist responded to Mrs. R.'s own implicit plea for acknowledgement, Mrs. R. reversed her attitude toward L. With acceptance of the therapy and cooperation at home, L.'s hostility rapidly decreased, and cooperation took the place of manipulation.

During the course of the year, four mother-teacher-therapist conferences took place. Although these provided only the minimum support required by Mrs. R. to allow L. to continue, it was obvious that the rapport

of the three adults involved was critical to the progress made by the child. Without some nurturing being available to L.'s mother, it is doubtful that L.'s playroom experience could have continued or have been effective.

CHILD: D.W. (I.D. #111031)

D. W. showed extreme discomfort in his classroom from the beginning of school in September until he began coming to the playroom in December. He was withdrawn, never talked, stood on the periphery during free play inside or outside, and often hid his face in his arms. He rarely ate any lunch and was fearful that his mother would find this out. His intellect and motor ability were clearly normal or above, and he was able to handle tools with dexterity. His predominant problem seemed tied up with his own identity and the absence of his father. At times he found it difficult to accept things he really wanted.

D.'s behavior in the playroom differed markedly from his classroom behavior, even from the first visit. He expressed himself fluently and carried on conversations consistent with or above his age level with the therapist. While able to involve himself in the therapy activities, he needed constant reassurance that he could return to his class whenever he wished. When he brought a friend to the playroom he needed to be in charge or else he seemed quite threatened. After his third visit his teacher reported that D. was quite cheerful for the remainder of that school day. At the end of four sessions D. was able to refer to himself as "I" instead of "me," the pronoun he had previously used when referring to himself as the subject. In class, he was able to participate in learning experiences and conversations, whether teacher or student directed. He had made several friends and seemed to enjoy outdoor playtime.

D.'s mother showed her resistance to D.'s playroom experience by telling him that only "bad boys" went there. D. regressed noticeably after her visits. Several conferences were necessary to keep Mrs D. agreeable to D.'s participation.

CHILD: S.H. (I.D. #111051)

S. H. was an attractive, slender, blonde-haired girl of good intellectual ability. Although she seemed comfortable at the beginning of the fall semester, when the class consisted of only four children, she began to demonstrate signs of emotional problems as the class increased in size. She began to hide her face in the dress of the teacher when the children were out in the yard and would curl up in the lap of any willing volunteer and feign sleep for as much as an hour at a time. She cried frequently and in general was a sad child.

Even before her first invitation to the playroom, S. had made contact with the therapist and asked to go along. Her behavior in

the regular class improved rapidly as soon as she had her special time in the playroom; within the first week S. had started to relate to peers during the outdoor play period instead of standing off by herself. Gradually her interactions with other children increased and she began to initiate contacts and participate in classroom activities.

CHILD: .D.M. (I.D. #112011)

D. M., a petite, pretty girl with curly blonde hair, weighed only 27 pounds although she was five years old. Her early development was reported as being retarded; she did not sit up until she was 13 months, took her first step at about two years, and spoke only a few words when she entered Head Start. She did not play with other children, nor seem to be aware of them much of the time. She had a very short attention span, and her body was in constant movement. It may be that a part of her delayed maturation was due to the fact that her mother continued to keep her in a crib long past her fourth birthday. The suggestion that D. might have suffered some degree of brain damage was ruled out by a comprehensive neurological examination. Her normality was confirmed by her phenomenal progress in school after she entered therapy.

D. came easily to the playroom and quickly ritualized her time there. She especially needed sameness and always asked for it. She was the only child who was totally uninhibited in using the nursing bottle. She brought a friend to the playroom with her and her relations with other children progressed rapidly. With the help of the therapist, D.'s speech improved rapidly and she became quite a fluent speaker. It seemed that D. had stored up a great deal and wanted to get it out as rapidly as possible.

D. demonstrated that she had above average ability and the prognosis for her future development seemed quite promising.

CHILD: C.W. (I.D. #111041)

C. W. was a pretty girl in spite of a pasty complexion and a toddler's waddle, which gave the impression that she had some deformity in her feet or legs. Her behavior was quite immature and withdrawn and her parents asked for special help because they felt something was wrong with her. They openly described her as the scapegoat of the family, and considered her to be mentally retarded. However, tests by two psychologists and a psychiatrist confirmed that she was at least average in intelligence.

In the first weeks of school she spent much of her time crouched in the doll corner making baby-like sounds and refusing to relate to peers or teachers. After several visits to the playroom, C.'s waddle began to give way to a much firmer gait. She was able to ride the tricycle and to keep up with the physical activities of her class. In fact she became so successful in giving up her babyish ways that her

parents became distressed. When D. returned to school after a few weeks absence she had regressed noticeably and the waddle had returned; however, within two weeks she was again approaching her optimal functioning.

By the end of the school year, C. had become outstandingly attractive in appearance and personality. When in a group of children she was often noticed first by adults, and was frequently chosen as a partner by many of the children in her class. Having worked through her need to act the role of a baby without censure, she was ready to proceed to more mature modes of behavior.

CHILD: J.P. (I.D. #111021)

J. P. came from a home where English was not spoken and so had little facility in the language when he entered Head Start. The social worker reported that there was a great deal of brutality in the home, and J.'s behavior was correspondingly aggressive and hostile. No further information about the family structure was available to the therapist.

When J. was brought to the playroom with another child he would get into a fight and chase the other child around the room. By the 12th session the teacher reported that J. had not hit another child in class. He loved crafts and music and after his session he was willing to enter class and participate. Although there were many setbacks when he again engaged in aggressive behavior, on the whole the therapist felt that he had made considerable progress over the 22 brief sessions.

CHILD: C.F. (I.D. #113011)

C. F. was a pleasant, bright child with good motor skills who behaved in a very immature fashion. She was hyperactive, talked constantly, and flitted from one thing to another. She would often come into the playroom, climb into the crib, get into a womb position, and suck the nursing bottle until it was empty. However, she felt guilty about this, saying, "I'm not a real baby. I don't go 'goo-goo' really. If I were a real baby I would be in trouble. My mommy sees me like a baby her's goin' to be in real trouble." After acting the baby role she usually asked for lipstick and other make up. Putting on make up seemed to be her favorite activity when she stopped using the nursing bottle. On her last visit she spent most of her time recording her singing on the tape recorder and then listening to the playback. Her babyish behavior had all but disappeared and she seemed to be able to function at a four-year-old level.